MEDICAL/DENTAL
INFORMATION RELEASE

I,___________________________________ , parent or legal guardian of ____________________________ give
(Guardian's Name) (Child's Name)

Pediatric Dental Specialists permission to release/obtain information contained in his/her medical/dental chart to:

To /From: _____________________________________
(Office Name)

____
(Street Address)

____
(City, State, Zip)

This information may include copies of medical/dental x-rays or photographs contained in the chart.

___________________________________ _______________ ________________________________
Signature of Parent or Legal Guardian Date Relationship to Child

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