



Date:

## REQUEST FOR RELEASE OF RECORDS

I (Patient's Name) \_\_\_\_\_ hereby request and give my permission to Dr. \_\_\_\_\_ to provide

Dr \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

any and all information which he/she may request with respect to the orthodontic care of  
(Patient) \_\_\_\_\_.

Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, x-rays, models and copies of all dental records and medical records.

I agree to pay the cost of duplicating any records. A photocopy of this release will be as effective and valid as the original.

Signed: \_\_\_\_\_ Date Signed: \_\_\_\_\_

\_\_\_\_\_  
(Patient)

S.S.N./S.I.N.: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

Signed: \_\_\_\_\_ Date Signed: \_\_\_\_\_

(Parent, Legal Guardian or Custodian of the Patient, if appropriate)

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_