Red Mountain
PEDIATRIC DENTISTRY

Record Release Authorization

Oftentimes it is necessary to obtain your complete dental history to create a treatment plan that will properly address all of your child's immediate and long term dental needs. This consent gives our office permission to obtain those records on your (or your dependents) behalf.

Patient Name _____ DOB_____

Previous Dentist Name _____

Address _____

City _____ State_____ Zip_____

I authorize Red Mountain Pediatric Dentistry to request and receive any and all previous dental charting and x-rays as they pertain to the above-named patient's dental health and treatment.

_____ _____

Print Name of Legal Guardian DOB

_____ _____

Signature of Legal Guardian Date