PRESTON CORNERS
PEDIATRIC DENTISTRY

Authorization to Release Health Information

I authorize Preston Corners Pediatric Dentistry to release my child's records/applicable radiographs to the office of:

Office Name: _____

Phone Number: _____

Email Address: _____

Patient Name(s): _____ DOB: _____

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

Signature of Responsible Party: _____ Date: _____

Relationship to Patient(s): _____

Please return this form to our office by email at **info@PrestonCornersPD.com*