RELEASE OF RECORDS FROM PREVIOUS PROVIDER

Patient Name: _____ Date of Birth: _____
First Last

Parent/Guardian Name:_____
First Last

As the parent/guardian of the patient listed above, I hereby authorize:

Name of Dental Office: _____

Address of Dental Office: _____

Phone Number of Dental Office: _____

To furnish dental records for the following patients:

_____ _____

_____ _____

_____ _____

To the following dental office:

The Tooth Fairy

1230 SW Harvey Street

Topeka, KS 66604

Signature:_____Date: _____