



## RELEASE OF RECORDS TO A NEW OFFICE

Parent/Guardian or Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
First Last

I, \_\_\_\_\_ hereby authorize:

The Tooth Fairy  
1230 SW Harvey Street  
Topeka, KS 66614

To furnish dental records for the following patients:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

To the following dental office:

Name of Office: \_\_\_\_\_

Address of Office: \_\_\_\_\_

Phone number of Office: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_