# Release of Records to a New Office

Parent/Guardian or Patient Name: ______________________Date of Birth: ____________

I, __________________________________hereby authorize:

The Kids Dentist

1230 SW Harvey Street

Topeka, KS 66604

To furnish dental records for the following patient(s):

_____________________________ _____________________________

_____________________________ _____________________________

_____________________________ _____________________________

_____________________________ _____________________________

To the following dental office:

Name of Office:________________________________________________

Address of Office:______________________________________________

Phone Number of Office:_________________________________________

Signature: ___________________________________________ Date: _________________