LittleSmiles
Children's Dentistry and Orthodontics

Medical Record Release Form

Date: _____

I _____authorize the release of medical records from Little Smiles

for the patient listed below. To Dr._____

_____

Patient Name Date of Birth

This release allows Little Smiles to receive a copy, photocopy or otherwise reproduce the records.

Records that you are authorized to release include those items checked below.

- ☐ Health History
- ☐ Dental History
- ☐ Dental X-rays (Most Recent)
- ☐ Dental Insurance Information
- ☐ All portions of dental and medical records, including hospital and physician office records

I further authorize and request that you accept a machine copy of this authorization as the original.

Signed:

_____ _____

Parent /Guardian Print Parent /Guardian Signature

_____

Witness Signature

Official use only

Reason of Release: _____

Staff: _____ Dr.'s signature: _____

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