Northwest Children's Dentistry

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Fax: (520) 877-7703
Email: team@nwkidsdds.com

AUTHORIZATION TO RELEASE PATIENT RECORDS

For each child you wish to release dental records, please list his or her name and date of birth.

	Patient Name	**Date of Birth**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

I hereby authorize Northwest Children's Dentistry to the release of dental records of the above-named patient(s) to the following provider:

Name of provider: _____

Address: _____

_____

Phone number for provider: _____

Reason for Transfer: _____

_____ _____

Parent/ Guardian Signature *date*

Email this form to: team@nwkidsdds.com