Dental Records Release Form

Date:_____

Patient Name(s): _____

_____

_____

I hereby grant permission to _____ to release dental record information and X-rays for the patient(s) listed above to:

Rocky Mountain Pediatric Dentistry
6071 E. Woodmen Rd
Suite 200
Colorado Springs, CO 80923

Ph. 719-638-7673
records@rockymountainpediatricdentistry.com

Parent/Guardian Signature:_____

(printed name and relationship to patient):_____