2863 Executive Park Dr. #101 Weston, FL 33331

Office # 954-217-1121 Fax # 954-217-1128

www.westonkidsdentistry.com

AUTHORIZATION FOR RELEASE OF RECORDS AND X-RAYS

1. ______________________________ (DOB) ______________________
2. ______________________________ (DOB) ______________________
3. ______________________________ (DOB) ______________________
4. ______________________________ (DOB) ______________________
5. ______________________________ (DOB) ______________________

*** FROM PRIOR OFFICE** To Pediatric Dentistry Of Weston
I authorize the transfer of all records, x-ray information to Pediatric Dentistry of Weston, for the above child(ren).

OFFICE NAME: ____________________________________ PHONE #: ____________________________

OFFICE EMAIL: ____

Parent/Guardian Signature: ______________________________ Relationship To Patient: ___________

*** FROM PEDIATRIC DENTISTRY OF WESTON** To New office
I authorize transfer of all records, including x-ray information for the child(ren) listed above **from** Pediatric Dentistry of Weston TO:

OFFICE NAME: ____________________________________ PHONE #: ____________________________

OFFICE EMAIL: ____

Parent/Guardian Signature: ______________________________ Relationship To Patient: ___________

Reason for Transfer: Relocate _____ 2nd Opinion _____ Insurance _____ Other _____

(if other please explain) ____

Parent/Guardian Signature: ______________________________ Relationship To Patient: ___________

**** Please note that all patient records are electronic in nature. We must be able to transfer digital films via email.**

Please allow our office 24-48 hours to process this request. THANK YOU!!

Office Use Only

Staff Initials: ________ Records Sent: ______________