



## Kulick Dental

7393 Broadview Rd, Ste G  
Seven Hills, OH 44131  
Phone - (216) 236-6300  
Fax - (216) 236-6304  
[staff@kulickdds.com](mailto:staff@kulickdds.com)

---

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Guardian Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

---

### REQUEST FOR RELEASE OF RECORDS

I \_\_\_\_\_ (*Name*) hereby authorize the release of my records relevant to dental treatment.

I \_\_\_\_\_ (*Parent/Guardian*) hereby authorize the release of records relevant to dental treatment for \_\_\_\_\_ (*Patient*).

Please send records to:  
**Kulick Dental**  
**7393 Broadview Rd, Ste G**  
**Seven Hills, OH 44131**  
Fax - (216) 236-6304  
Email - [staff@kulickdds.com](mailto:staff@kulickdds.com)

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

