Sutton Children's
Dentistry & Orthodontics

Dental Records Release

Patient Name: _____ DOB:_____
Relationship to Patient: _____

Information to be used or disclosed:

- ❑ • Entire dental record
- ❑ • My dental information relating to a treatment or condition:
  _____
- ❑ • Most recent X-Rays
  - ❑ • Bitewings
  - ❑ • Panoramic/FMX
  - ❑ • Periapical #_____

This section to be completed if requesting records be sent to Sutton Children's Dentistry and Orthodontics from another Dental practice:

Outside Office Information:
Name: _____
Address: _____
City/State/Zip:_____

Please email the patient's records to info@suttonkidsdental.com

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This section to be completed if requesting records be sent from Sutton Children's Dentistry and Orthodontics to another Dental practice:

Outside Office Information:
Name: _____
Address: _____
City/State/Zip:_____
Phone Number: _____
Email Address: _____

Authorization and Signature: I authorize the release of my confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information.

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_____

_____

Signature of Parent/Patient Date