Smiles 4 Kids
Children's General Dentistry

MEDICAL RECORD RELEASE FORM

I, _____, give permission to Smiles 4 Kids General Dentistry to:

☐ Release my child's dental records. ☐ Obtain my child's dental records.

Child's Name: _____ D.O.B: _____

Parent Name: _____

Address: _____

Phone #: _____ Fax #: _____

Email: _____

☐ To be released to: ☐ To be obtained from:

Dental Office Name: _____

Address: _____

Phone #: _____ Fax #: _____

Email: _____

Parent/Guardian Signature: _____ Date: _____

Services provided by Colorado Licensed General Dentist
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