

Just Kids



Pediatric Dentistry

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REQUEST FOR RELEASE OF DENTAL RECORDS AND X-RAYS

I hereby request that my child/children's dental records and x-rays be released to:

TO: _____

Date: _____

Parent/Legal Guardian Name (Printed): _____

Parent/Legal Guardian Name (Signature): _____

For the Child/Children: _____

Date of Birth: _____

Date of Birth: _____

Date of Birth: _____

Date of Birth: _____

Comments: