Pediatric Dental
ASSOCIATES

Board Certified Pediatric Dentists

Records Release Request

I hereby authorize and request you to release to:

PEDIATRIC DENTAL ASSOCIATES

Email: confirm@pediatricdental.com

The complete dental records, including all x-rays, in your possession concerning the treatment of:

Patient(s) Name	D.O.B.
______________________________	________________________
______________________________	________________________
______________________________	________________________
______________________________	________________________

Thank you for your prompt attention to this matter.

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Signature (Parent or Guardian) / Date

Pediatric Dental Associates ~ 192 Main Street ~ Manchester, CT. 06042
PHONE: 860-649-4655 FAX: 860-646-3281