A TO Z PEDIATRIC DENTISTRY

RECORD RELEASE FORM

As parent or legal guardian, I do hereby give consent to A to Z Pediatric Dentistry to release a copy of my child's confidential dental/medical record to myself:

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It is my understanding that these records will then become an official part of new records at the requesting dental office. I further recognize that A to Z Pediatric Dentistry is no longer responsible for any incomplete treatment and that my file will be inactivated. There will be a $30.00 fee for each record duplicated. I also release Dr. Clark and A to Z Pediatric Dentistry from any responsibility in providing additional duplicate records in the future.

______________________________	____________________
Parent or Legal Guardian Signature	Date
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Witness Signature	Date