KIDZ KORNER DENTISTRY

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RECORD RELEASE FORM

I, _____, request that (child's name) treatment record be released, duplicated, and or forwarded to me (or dental office).

Please mail the duplicate information to:

_____ _____
Please print your name (Parent/Guardian) Telephone Number

_____ _____
Parent/Guardian signature Date

_____ _____
Patient's Name Patient's Date of Birth