

# MEDICAL RECORDS RELEASE FORM

Childrens Dentistry  
1551 S. Renaissance Towne Dr.  
Suite 540  
Bountiful, UT 84010  
801-295-8322  
Fax: 801-295-7694

Dr. or Clinic you are requesting records from: \_\_\_\_\_

Phone/ Fax (if applicable): \_\_\_\_\_

I, \_\_\_\_\_ hereby request and authorize the release of medical records for:  
Parent, Patient/ Legal Guardian

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

If there are additional patient records please fill out an additional form and attach it to this one.

Please specify where you would like the records to be sent: (name, address, phone, and fax) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Special Instructions: \_\_\_\_\_

\_\_\_\_\_

Thank you,

Authorization Signature

\_\_\_\_\_  
Parent, Patient/ Legal Guardian

Date: \_\_\_\_\_

Information contained in this fax transmission is strictly confidential and for the use only by the above named individuals.