Release Form

I hereby authorize Central Park West Orthodontics to release the patient records for

_____
(Name of Patient)

To the following person(s):

☐Parent/Guardian
☐ New Dentist
☐Other: _____

_____
Name of Patient or Parent/Guardian

_____
Signature of Patient or Parent/Guardian

Why are you requesting records?

_____

Date: _____

***New Dentist information**
Name of Dentist: _____

Telephone: _____

Address: _____

City: _____ State: _____ Zip_____