Frisco Dentistry for Kids
Caring for Infants, Children, & Adolescents

Dental Records Release Form

By signing this form, I authorize you to release confidential heath information about my child/children, by releasing a copy of the dental records, images or narrative of my child's/children's protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Release the protected health information to the following physician/person/facility/entity and/or those directly associated in my child's/children's dental care.

Name:_____

Address: _____

City, State, Zip code: _____

Email: _____

The purpose/reason for this release of information is as follows:

_____

_____

Parent/Guardian Name:_____

Parent/Guardian Signature: _____Date: _____

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