RECORDS REQUEST

I authorize the release of dental records and most recent x-rays for the patient(s) listed below:

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Forward the records to:

Dentistry for Children of West Essex, LLC
412 Pleasant Valley Way
West Orange, New Jersey 07052

Email x-rays to:

DFC412@gmail.com

Parent's Name: _____

Printed

Parent's Signature: _____ date: _____