Children's Dental Columbia

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Please release dental records to:

Practice/Doctor:____

Address:____

City, State, Zip:____

Email:____

Phone:_________________________________Fax:__________________________________

I hereby authorize the copy and release of dental records for my child/children:

Name and DOB:____

Name and DOB:____

Name and DOB:____

Name and DOB:____

Name and DOB:____

***This form may only be signed by a biological parent, legal guardian, or patient (18 years and older).**

Signature:____ **Date**:________________________________