BrightSmiles4Kids

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**The undersigned acknowledges their lawful authority to request the release of a patient's record. The undersigned and listed patient(s) has hereby requested the transfer of said records. Last current electronic images will be sent to new provider of service via email at no charge. Full records will be released within 14 business days of notification from the Guardian/Parent for a $25 fee.**

I, _____, hereby request and authorize Bright Siles 4 Kids Pediatric Dentistry & Orthodontics, to release the following personal health information: for the following patient(s),

_____, DOB_____ Phone number: _____

_____, DOB_____ Phone number: _____

To:

Name: _____

Address: _____

Phone number: _____

Email: _____

***The facility, its employees and the attending dentist(s) are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized by this release. I am accepting responsibility for these records and for the protection of my own right of medical record confidentiality.***

**Guardian Name: _____**

**Guardian Signature: _____ Date: _____**