Kalispell Kidds

Pediatric Dental Specialists

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS AND RADIOGRAPHS

Date of Request: _____

I, (print parent/guardian name) _____, hereby authorize the dentist and staff of Kalispell KiDDS to release my child's/children's dental records and/or radiographs.

Describe the records you wish to access and the approximate dates of the records:_____

_____

Patient Name/s:

1. _____ DOB:_____
2. _____ DOB:_____
3. _____ DOB:_____
4. _____ DOB:_____

Contact phone number (if any questions): _____

Please transfer records to:

Practice/Dentist Name _____

Street Address _____

City, Zip Code _____

Telephone & email _____

Signature of parent/guardian: _____

Printed Name/relationship to child: _____

Please complete this form and fax it to (406)756-1143.

For dental office use only:

- ☐ Request for access denied (attach written denial).
- ☐ Request for access approved.

If approved, describe below when and how access was provided. If an electronic copy was provided, describe the form and format of the electronic copy.

_____

60 Four Mile Drive Suite 10 • Kalispell, MT 59901 • Phone: 406-756-1142 • Fax: 406-756-1143