JASON C. BARB, DDS
TODD BERNARD, DMD
JOHN M. VENZEL, DMD

Authorization to Release Dental Records

Patient's Name: _____ Birthdate: _____

Patient's Name: _____ Birthdate: _____

Patient's Name: _____ Birthdate: _____

I request and authorize Kidsmile, Inc. to send the dental records of the patient(s) named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Kidsmile, Inc. may request a $25.00 duplication fee. Duplication of records will be processed within 30 days of receipt of request.

I authorize Kidsmile, Inc. to duplicate, use or disclose my protected health information to the address above.

_____ _____

Parent/Legal Guardian Signature Date

Revised 5/2019