Records Release

I, _____, give Dr. Deborah Himelhoch's office permission to release/transfer copies (including radiographs and photographs, if applicable) of my own/my child/children's dental records to:

_____
(Doctor/Hospital/Family Member)

Address:_____

City:_____ State:_____ Zip:_____

_____
Print Name of Patient or Patients

From:_____To:_____
Date of Records Date of Records

_____
Patient's/Parent/Guardian Signature Date