Release of Records

Please complete this form thoroughly. You and your child's dental records cannot be released until this form is completed and signed by the patient (or if under 18 their parent or guardian). Please allow 1 week for processing.

Please Email this Form to smiles@mychildrensdentist.com or Fax to: 508-393-9364

Patient Information:

Patient Name: _____Date of Birth: _____

Patient Name: _____Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell: _____ Email: _____

I authorize Children's Dentistry of Northborough to release the following information:

_____ **Dental Radiographs ONLY:** First time no charge

_____ Email*

_____ **Dental Records with Chart Notes:** $25 Processing Fee

_____ Email*

_____ Parent pick up (all radiographs can only be emailed)

* I agree that I will be responsible for ensuring proper receipt of the email and that I will contact the office within one week should the images and records not be received. I understand that email is not 100% reliable and is subject to internet privacy issues. If a second email is required after one week a $5.oo processing fee will be charged for staff time.

This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date.

Reason for leaving the practice: _____

Guardian Signature: _____**Date**: _____