Reid & Reid
Pediatric Dentistry • Orthodontics

RECORDS RELEASE REQUEST

Date_____

To _____
(Doctor)

_____
(Address)

_____
(City, State & Zip)

I authorize the release of dental records and medical records relevant to dental treatment, or copies of such, and request that they be transferred to:

Reid & Reid Pediatric Dentistry and Orthodontics 685 Blythe St. Ct, Suite B Hendersonville, NC 28739 (828) 696-2245 Fax (828) 696-2022 frontdesk@reidandreid.net

_____
Print Name of Patient

_____
Signature (Patient, Parent or Guardian)