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

_____
Print Name of Patient

_____
Signature (Patient, Parent or Guardian)