DAVID C. ADAMS, D.D.S., M.S., AND ASSOCIATES

SPECIALISTS IN ORTHODONTICS FOR CHILDREN AND ADULTS
SPECIALISTS IN PEDIATRIC DENTISTRY

Request for Release of Records

I, ________________________________ hereby request and give my permission to

Dr. Adams to provide Dr. ______________ any and all information requested with

respect to the pedodontic care of ___________________.

Such records may include medical care, treatment, illness or injury, dental history, medical history, consultation, prescription, x-rays, models and copies of all dental records and medical records.

I agree to pay the cost of duplicating any records. A photocopy of this release will be as effective and valid as the original.

Signed: ____________________________
Patient

Signed: ____________________________
Parent or Guardian

Date: ____________________________

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NORTH COUNTY 2125 EL CAMINO REAL, SUITE 101 / OCEANSIDE, CA 92054 / 760-433-0393 / FAX 760-439-0282

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