**DAVID C. ADAMS, D.D.S., M.S.**

*SPECIALIST IN ORTHODONTICS FOR CHILDREN AND ADULTS*
*SPECIALIST 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 orthodontic care of __________________.
Patient's name

Such records may include medical care, treatment, illness or injury, dental history, medical history, consultation, prescriptions, 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: ___________________________________

SAN DIEGO 239 LAUREL STREET, SUITE 201 / SAN DIEGO, CA 92101 / 619-291-5266 / FAX 619-291-0124

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

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