Children's Dentistry
of Charlottesville

1470 Pantops Mountain Place
Charlottesville, Virginia 22911

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434.817.1817(phone)
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Record Release Form

Patient's Name _____ Date of Birth:_____

Parent's Name _____ Social Security #_____

I request and authorize_____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates: _____
  _____
- All healthcare information
- Other: _____

Parent/ Guardian Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED