Release of records

I give permission to Little Chompers Pediatric Dentistry to discuss and request necessary medical records from any physician facility named below:

Primary care Physician: _____

Hospital/other: _____

Patient name: _____ DOB: _____

Parent/Guardian signature: _____

Parent/Guardian printed: _____ Date: _____

Permission signature by patient/parent/guardian is valid for 1 year from signature date.