REQUEST FOR RELEASE OF RECORDS

Date : _______________

I, (patient or parent's (if patient is under 18 years of age) name) ____ hereby request and give my permission to Dr. Kleinlerer to provide

Dr. ____

Address: ____

City: ________________________ State: ___________ Zip/Postal Code: ______________

any and all information which he/she may request with respect to the orthodontic care of (patient) ____.

Such records may include medical care and 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: __________________________________ Date Signed: ____________________

Phone: ____________________________________

Address: ____