HAASDENTAL
DOVER

I, _____, authorize Haas Dental Dover to
(print name)

OBTAIN or **RELEASE** (circle one) records such as radiographs, clinical notes, etc., pertaining to minor child(ren):

_____

Records should be **obtained/released from/to**:

Practice Name: _____

Address: _____

_____

Email: _____

Reason for Request: _____

Limitations (if any): _____

I understand that this release will be in effect until such time as it is revoked by me in writing.

_____ _____

(**Signature**) (**Date**)

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