Children's Dental Clinic
of Las Cruces

RELEASE OF DENTAL RECORDS/XRAYS

This form does not authorize the release of information other than that specifically described below

Patient name: _____

Date of Birth: _____

Social Security number: _____

Address of patient: _____

Phone number: _____

Release to: _____

_____
__

Information Requested:

___ Copy of complete dental chart ___ Copy of dental xrays

_____
__

A copy of this authorization or my signature may be used with the same effectiveness as an original

_____ _____ _____
Date requested Parent or guardian signature Relationship to patient

RECORDS SENT ON: _____

SENT BY: _____