Record Release Form

I, ____ hereby authorize
(Legal Guardian or Custodial Parent's Name)

____ to provide
(Dentist or Physician's Name)

Little Teeth of Texas Dentistry for Children, P.A., Shawna Billick-Gerling D.D.S., with copies of my child's dental or medical records with respect to any care or treatment needed.

Child's Name: ______________________________
Child's Date of Birth: _________________________

I understand that the specific type of information to be disclosed includes a detailed report of examinations, findings, treatment, prognosis, and copies of any and all other records, including x-rays, which pertain to my child.

This consent is effective until such date as I can cancel this consent. I understand that information obtained as a result of this consent may be used after the cancellation date.

Signed: ____
(Legal Guardian or Custodial Parent's Name)

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