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RECORDS RELEASE REQUEST

I hereby authorize release of dental records for my child,

Please PRINT child's name

Dental records requested are:

- Bitewing x-rays
- Other intraoral x-rays
- Panoramic x-rays
- Chart

***The records requested will be mailed to the patient's home address we have on file.**

***Reason for request:** _____

(Please allow at least 2 (Two) weeks for Processing.)

Parent's signature

Date

Massachusetts General Laws Chapter 112, section 12CC and Board Regulation 234 CMR 2.04 require dental practitioners to provide copies (not the originals) of patient records upon written request at a reasonable duplicating fee. The cost of this duplication is \$25.