

Dr. Barrett J. Parker Orthodontics

Date: _____

REQUEST FOR RELEASE OF RECORDS

I (Patient's Name) _____ hereby request and give my permission to **Dr. Barrett J. Parker D.D.S.,M.S.** to provide

Dr. _____

Address: _____

City: _____ State/Province: _____ 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: _____
(by patient if 18 or older)

Signed: _____ Date Signed: _____
(Parent, Legal Guardian or Custodian of the Patient, if appropriate)

Phone: () _____

Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____