Kind Kids DENTAL

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Record Release Authorization Form

PATIENT FIRST NAME _____ PATIENT LAST NAME _____ DATE OF BIRTH _____

Please list the names and birth dates for ALL children with records to transfer:

I would like to:

☐ Transfer from prior office **TO** Kind Kids Dental

☐ Transfer **FROM** Kind Kids Dental to a new office

Please provide the name and location of the clinic(s) that you are either wanting us to send info to or get info from, including email address:

_____

_____

_____

If you are leaving our practice, please provide a reason why. How can we do better?

_____

_____

_____

Parent/Guardian Print Name

_____ _____

Parent/Guardian Signature Date