I, ____ hereby request and authorize
(Parent Name)

Jessie M. Banks DDS
Kitsap Kid's Dentistry

To release my child(ren)'s dental records to:

____
(Name of Dentist) (Phone) (Fax)

____
(Street Address) (City) (State) (Zip)

____
(Name of Parent) (Phone) (Fax)

____
(Street Address) (City) (State) (Zip)

- -

____
(Patient Name) (DOB)

____
(Patient Name) (DOB)

____
(Patient Name) (DOB)

____
Signature of Parent/Guardian **Date**

NOTE: To recipient of information. This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains. (Charges may apply for copies of records).