Kidsworld Pediatric Dentistry

Authorization for Release of Dental Records and X-rays

Date: _____

I, _____ hereby authorize

Office:

Address:

Phone #:

Fax #:

To release the following dental records, radiographs, and insurance information for:

_____
Name(s) of family member(s)

Date of New Patient Exam:

Date of last Recall Exam and Hygiene Appointment:

Date of last Radiographs (Please forward a Duplicate of most recent):

Insurance Company and Policy Number:

Please forward records and radiographs to:

Kidsworld Pediatric Dentistry
Dr. Priya Kothari
222 Wellington St. East, Suite 200
Aurora, ON L4G 1J5
Phone: 905-503-5300 **Fax:** 905-503-5302
Email: kidsworlddentistry@gmail.com

Signature of Patient/Parent or Guardian: _____