Ankeny Children's Dental

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Specializing in Dentistry for Infants, Children, Adolescents, and Children with Special Health Care Needs

Authorization for Release of Dental Records

I hereby voluntarily authorize the use and/or disclosure of my dental information as described below. This authorization is effective for one year from the date on which it was signed. I understand that I may revoke this authorization at any time, except if action has already been taken in reliance upon it, by giving written notice to Ankeny Children's Dental. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by Ankeny Children's Dental.

Transfer/Release of X-Rays for:

Patient(S) Name: _____

Patient's Date of Birth: _____

_____ I hereby request copies of my x-rays held by _____

to be transferred to Ankeny Children's Dental.

_____ I hereby request copies of my x-rays held by Ankeny Children's Dental to be transferred to: _____

Signature of Patient or Legal Guardian: _____

Today's Date: _____

FOR OFFICE USE:

Date of Last Visit: _____

Date of Last Bitewings: _____

Date of Last PANO: _____

Date of Last Cleaning: _____

Date of Last Fluoride: _____