REQUEST FOR RELEASE OF RECORDS

Date : _____

I, (patient or parent's (if patient is under 18 years of age) name) _____ hereby request and give my permission to Dr. Kleinlerer to provide

Dr. _____

Address: _____

City: _____ State: _____ 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: _____

Phone: _____

Address: _____