3000 Hampton Center, Suite B
Morgantown, WV 26505
304-599-5000
Website: www.dentist4kids.org
Email: dentist4kids@emailsafe.us

RECORDS RELEASE TO AUTHORIZED AGENT

Patient Name: ________________________________

DOB: _________________

Parent/Legal Guardian Name: ____

Phone Number: ____________________________________

I authorize release of my dependent's dental records to the following dentist:

Dentist Name: ____Dr. Day/Turak/Morgan__

Dentist Phone: ____304-599-5000__________

Dentist Email: ____dentist4kids@emailsafe.us

Dentist Fax: ______304-599-6629__________

____ _________________

Signature of Parent/Legal Guardian Date