

Request for Dental Records



Children's Dental Columbia

Send to Children's Dental Associates of Columbia
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Please release records from the following:

Former Dentist: _____

Address: _____

City, State, Zip: _____

Email: _____

Phone: _____ **Fax:** _____

I hereby authorize the copy and release of dental records for my child/children:

Name and DOB: _____

Name and DOB: _____

Name and DOB: _____

Name and DOB: _____

Name and DOB: _____

***This form may only be signed by a biological parent, legal guardian, or patient (18 years and older).**

Signature: _____

Relationship _____ **Date:** _____