primary teeth
pediatric dentistry

Jake Fried DDS

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RECORDS RELEASE REQUEST

I, _____ hereby authorize the release of my child(ren)'s bitewing x-rays, panoramic x-rays, and any other form of dental records to Primary Teeth Pediatric Dentistry. I authorize _____ to release the records to the designated name, address and/or e-mail:

Primary Teeth Pediatric Dentistry
199 S. Main St. Gloversville, NY 12078
Phone: 518-601-2220
Fax: 518-601-2221
Email: info@primaryteeth.com

Patient's Name(s): _____

_____

_____

Date of Birth(s): _____

_____

_____

[Relationship To Patient]

_____ _____

[Signature] [Date]