Chester County Dentistry for Children

&

The Orthodontic Group

Request & Authorization for Release of Records

Please circle if the record request is for our **Orthodontic Group** or **Pediatric Dental Group**.

Date: _____

Patient Name & Date of Birth: _____

Reason for Transfer: _____

Authorization for Release of Records:

I authorize the release of my child's dental or orthodontic records.

_____

Parent's Signature: Date:

Please email x-rays and or clinical notes to the following email address:

_____

Please email or fax this completed form to the appropriate office for record transfer.

Lionville Fax: (610) 363-2120 Email: lionville@chestercountydentistry.com

West Chester Fax: (610) 918-2424 Email: westchester@chestercountydentistry.com

Kennett Square Fax: (610) 925-0400 Email: kennettsquare@chestercountydentisry.com