Eric S. Campbell, DDS, MDS, PA

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Request for Release of Records

I, _____, hereby request and give my permission to Eric S. Campbell, DDS, MDS, PA to provide Dr. _____ any and all information he/she may request with respect to the orthodontic care of _____.

Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, orthodontic x-rays, intraoral and/or extraoral photos, and models, and copies of any pertinent dental records and medical records on file with said provider.

Signed: _____
Patient

Signed: _____
Parent, legal guardian or custodian of the patient if a minor

Address:_____
Street

_____
City, State, Zip Code

Date Signed: _____

Please fill in complete name, address and phone number of transfer Orthodontist below:

(please print)

Orthodontist Name _____ Phone (___)_____

Address _____

_____