pediatric dental at Bridgeport
Ben Kang DMD,MS,PC
Board Certified Pediatric Dentist

MEDICAL/DENTAL RECORDS RELEASE

Patient Name: _____

Address: _____

_____

I hereby request and authorize Pediatric Dental at Bridgeport to disclose and release all medical/dental records to the Dental/Medical office below. Including, but not limited to any and all office records, hospital records, hospital charts and x-rays.

To: _____

_____

_____

A copy of this authorization shall be considered as effective and Valid as the original.

Today's date: _____

Patient Relationship: _____

Signature: _____

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