Request for Release of Records

I, _____, hereby request and give permission to Dr. Ileana Cavanagh to provide
(Patient's or Parent's / Guardian's Name)

Dr. _____

Address _____

City _____ State _____ Zip _____

any and all information which he /she may request with respect to the orthodontic care of

_____ .
(Patients Name)

Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, x-rays, models, and copies of all dental records and medical records.

I agree to pay the cost of duplicating any records. A photocopy of this release will be as effective and valid as the original.

_____ _____
Patient's (Parent's / Guardian's) Signature Date

Phone # _____

Address _____

City _____ State _____ Zip _____