Haring PEDIATRIC DENTAL

Practice Limited to Pediatric & Adolescent Care

Release of Records

Dr. Robert S. Haring, D.D.S., MS
Dr. Nick Kerns, D.D.S., MS
Dr. Joel Richards, D.D.S.

Name(s) of patient _____

I hereby authorize Haring Pediatric Dental to release dental records to Dr. _____
I understand I may revoke this content at any time to the extent that the action has already been taken and that it will expire ninety days from the date below.

Haring Pediatric Dental is hereby relieved from all legal responsibilities or liabilities for the release of the information described above to the extent indicated and authorized herein.

Please check one:

☐ Mail my child(ren)'s records to: _____

Address: _____

_____

Phone number: _____

☐ Email: _____

_____

Signature of Patient/Guardian Date