

## Dental Records Release Form

I, ( parent or guardian's name) \_\_\_\_\_, hereby authorize the doctor and staff of Dr Elaine Martinez-Koziol to release records (I am requesting that you release the following (check 1 or both):  
\_\_\_\_\_ all x-rays , \_\_\_\_\_ all treatment notes and treatment plans) concerning my child(ren) dental health to (select one):

\_\_\_\_\_ 1. Given to a guardian (if patient is a minor)

\_\_\_\_\_ 2. Sent directly to a dental office (provide email if sent by email)

Name of Dental Practice: \_\_\_\_\_

Email of Dental Practice: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

\_\_\_\_\_ 3. Given directly to me ( If 18 years of age or older)

Please complete this form and bring it to our office or fax it to, Fleming Island (904)215-9887, Oakleaf (904)404-4440. Or you may email it to: [frontoffice@drelainemartinez.com](mailto:frontoffice@drelainemartinez.com) (a government issued ID must be presented) Upon request, the records can be mailed or emailed to your new dentist. **The records will only be released to another individual in the event that the records belong to a minor child.**

Please list name(s) of child(ren) :

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(signature of parent or guardian)