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 (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)