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## Request For Release Of Records

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

Dr \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

\_\_\_\_\_  
(Patient's 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 Number: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_