Kids to College
Pediatric Dentistry

AUTHORIZATION TO RELEASE DENTAL INFORMATION

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Street Address: _____

City: _____ Zip Code: _____ Phone: _____

I hereby authorize the dental records of the above named patient(s) to be released to:

Recipient Name: _____

Street Address: _____

City: _____ Zip Code: _____

By Courtney R. College, DDS MS PC

I certify that this Authorization has been made voluntarily. I understand that I may revoke this Authorization at any time except to the extent that action has already been taken to comply with it. A copy of this Authorization with my signature may be used with the same effectiveness of this original.

Reason for release of records: _____

Signature: _____ Date: _____

Please either mail or fax to:
Kids to College Pediatric Dentistry
Fax: 303.979.0140

31955 Castle Court, suite 2 North
Evergreen, Colorado 80439
303.674.0779

10146 W. San Juan Way, Suite 220
Littleton, Colorado 80127
303.979.9500