**Uehara Family Cosmetic Dentistry**
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# AUTHORIZATION TO RELEASE DENTAL RECORDS

(For Minor)

Date _____

I, _____,

Parent/Legal Guardian of _____,

**authorize Uehara Family Cosmetic Dentistry to release all dental records to:**

_____
Name of Doctor

_____
Doctor's email address

_____
Address

_____
City, State, Zip Code

**I release Uehara Family Cosmetic Dentistry from all liability that may result from the release of these dental records.**

_____
Signature of Parent / Legal Guardian