Aloha Pediatric Dentistry

Release of Records

Patient(s) Name: _____

Patient(s) DOB: _____

I hereby request and authorize the release of dental records, including radiographs, and/or other available charting information to the following named Dental Practice/Doctor:

Practice/Doctor: _____

Mailing Address: _____

_____

Email Address: _____

_____ _____

Signature (of parent if patient is a minor) **Date**

To help us improve patient care, we'd love to know why you decided to no longer see us: _____

_____

Berkeley Office
2640 Telegraph Ave #101
Berkeley, CA 94705
(510) 848-6494
FAX (510) 848-9329

North Berkeley Office
906 Ensenada
Berkeley, CA 94707
(510) 528-1546
FAX (510) 528-4362

Orinda Office
3 Altarinda Rd. #210
Orinda, CA 94563
(925) 253-8190
FAX (925) 253-8199