



California authorization for the release of dental records

I hereby authorize **Antioch Brentwood Pediatric Dentistry**, to release the
dental record of _____

to: _____

(name of dentist, physician, clinic, or patient's representative)

(address or email)

This authorization is effective now and will remain in effect
until _____ (date).

I understand that I may receive a copy of this authorization.

Signed: _____ Date: _____

(parent or guardian of minor patient)

www.abkidsdent.com

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