



REQUEST FOR RELEASE OF
HEALTH INFORMATION

I, _____(Print Name), hereby grant permission to

(Print Name of Dentist)

To release any and all information including but not limited to health history, status, treatment, copies of records, x-rays, and any test results for my child:

(Print Name of Child)

To:

Doris Lin-Song, DDS, Inc.
Bergen James, DDS
Jennifer Yu, DDS

Please email any digital x-rays to info@oneparkerdentistry.com

Date of Upcoming Appointment : _____

Parent/Guardian Signature

Date