Children's
DENTISTRY
~OF RANCHO CUCAMONGA~

9469 Haven Avenue, Suite # 100
Rancho Cucamonga, CA 91730
P: 909-483-6851 • F: 909-483-6853
www.RanchoKidsDentist.com

AUTHORIZATON TO RELEASE PATIENT RECORDS

I, _____, hereby authorize and request the release of the records and x-rays concerning any and all treatment rendered. Please forward within five working days.

Requesting records for:

Records to be released to:

Children's Dentistry of Rancho Cucamonga
9469 Haven Avenue, Suite #100
Rancho Cucamonga, CA 91730
Office@ranchokidsdentist.com

Thank you for your cooperation.

Signature_____**Date**_____