Records Release Form

Please fill out this form and send or fax it to your current dentist *before* your child's appointment with us. It is preferable to have your child's records and any films sent to our office prior to his/her appointments so that Dr. Summers has ample time to review them.

To whom it may concern:

Please release my child(ren)'s dental records and most recent x-rays to:

Livingston Pediatric Dental Associates
315 East Northfield Road
Suite 2-C
Livingston, NJ 07039
973-992-5555 phone
973-992-1166 fax
info@livingstonpediatricdental.com

_____ _____
Parent signature Date

_____
_____
_____
Address

Child(ren) name: Date of birth

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_____
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