the littletooth company

PEDIATRIC DENTISTRY

Jason Leung, DMD
264A Queen Street
Southington, CT 06489
Ph (860) 426-2643
Fax (860)426-1029

140 Grandview Ave,
Suite 102
Waterbury CT 06708
Ph (203) 518-8250

I _____ authorize the release of my child(ren's) dental records
(Parent/Guardian Name)

From The Little Tooth Company **to** _____
(New Dental Office)

Receiving Office Email: _____

Receiving Office Phone: _____

Patient Name: _____ **Date of Birth:** _____

Patient Name: _____ **Date of Birth:** _____

Patient Name: _____ **Date of Birth:** _____

Patient Name: _____ **Date of Birth:** _____

I understand that the requested records will be sent confidentially to the recipient(s) listed on this form, and that I may need to sign a subsequent release if records will need to be sent elsewhere in the future.

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____ **Date:** _____