



Dr. Natalie Carr
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AUTHORIZATION FOR RELEASE OF RECORDS

I hereby authorize Carr Pediatric Dentistry, PA to release records of the following (please note that there is a \$25 charge to prepare and send records):

1. _____
Last Name First Name MI DOB

2. _____
Last Name First Name MI DOB

3. _____
Last Name First Name MI DOB

4. _____
Last Name First Name MI DOB

Reason for request of records:

Child graduated to general dentist Second opinion Moving
 Insurance changed Changing dentist

Records to be sent to (Name, address, and phone number of dentist):

If Via E-mail (please note that e-mail may not be via a secure Server).

Email address of the dentist: _____

Name and phone number of the dentist: _____

Parent/Legal Guardian Signature: _____ Date: _____

Parent/Guardian Address:

