

Sea of Smiles Pediatric Dentistry

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Records Release

Date: _____

I, _____ authorize the release of **Dental**
(print name of parent/guardian)

Records for the following patient(s):

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

Please send them by mail or email to : (unencrypted email) I understand it may be unprotected by federal or state law

I understand that my records may be subject to re-disclosure by recipients and unprotected by federal law.

Please allow _____ to pick up a copy of the above patients(s) records (including other information from other dental providers)

Signature
(parent/guardian) _____ Date _____