Armstrong Pediatric Dental, LLC
Healthy Smile Center

Susan A. Armstrong, DDS

Specialty Permit #5405

Diplomate, American Board of Pediatric Dentistry

Record Release Authorization Form

Date: _____

I hereby give permission to release copies of my child (ren)'s x-rays and/or records to the following provider of services:

Children:

Name: _____ D/O/B: _____

Name: _____ D/O/B: _____

Name: _____ D/O/B: _____

Name: _____ D/O/B: _____

Provider:

Practice/ Dr. Name: _____

Address: _____

Phone: _____

E-Mail: _____

Fax: _____

Reason for transfer: _____

_____

_____

Parent/Guardian Signature: _____