

Southern Maine Pediatric Dentistry

Whitney R. Wignall D.M.D., M.Sc.

I, _____, authorize Southern Maine Pediatric Dentistry to release dental
(Parent/Legal Guardian)

records and xrays concerning _____ to:
(Patient's Name & DOB)

Clinic/Doctor Name/Other _____
Address _____

Reason for request _____

I understand that the dental records maintained by Dr. Whitney Wignall may contain dental and administrative information from other healthcare providers. I also understand that the practice of Dr. Wignall may charge a copy fee for the duplication of x-rays and records.

This authorization shall remain in effect until revoked by me in writing. All prior authorizations, if any, are hereby cancelled.

(Signature of Parent/Legal Guardian)

(Date)

(Address)

(Phone Number)

Pediatric Dentistry

(Witness Signature)

(Date)