



Westerville

PEDIATRIC DENTAL

Practice Limited to Pediatric & Adolescent Care

Release of Records

Dr. Joel Richards, D.D.S.

Name(s) of patient _____

I hereby authorize Westerville Pediatric Dental to release dental records to Dr. _____
I understand I may revoke this content at any time to the extent that the action has already been
taken and that it will expire ninety days from the date below.

Westerville Pediatric Dental is hereby relieved from all legal responsibilities or liabilities for the
release of the information described above to the extent indicated and authorized herein.

Please check one:

Mail my child(ren)'s records to: _____

Address: _____

Phone number: _____

Email: _____

Signature of Patient/Guardian

Date