

**Kids and Family Dentistry**  
**General Dental Records Release Form**

I request and authorize Amir R. Fereydouni, DMD to release copies of my dental records.

Patient or guardian pick up records? Y / N

Please send my dental records to:

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**I understand that these records may contain confidential information about my health history, financial records, dental conditions, progress notes and dental x-rays.**

**\$25.00 fee for copies of all dental records**

**Please allow 24-48 hours for completion**

Patient Name (print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Legal Guardian Name (print): \_\_\_\_\_

Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_