



Date: _____

REQUEST FOR RELEASE OF RECORDS

I, _____ hereby request and give my permission to
(Patient's Name)

Dr. _____

Address: _____

City: State: Zip Code: _____

to provide

William K. Farrar Jr., DDS, MDS
1635 Old 41 Hwy NW, Suite 112-276
Kennesaw, GA 30152

Fax: 678-401-6263

any and all information which he/she may request with respect to the orthodontic care of

(Patient's Name)

Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, x-rays, models, financials and copies of all dental records and medical records.

A photocopy of this release will be as effective and valid as the original.

Signed: _____ Date Signed: _____
(Patient)

S.S.N.: _____

Phone: (____) ____ - _____

Address: _____

City: State/Province: Zip/Postal Code: _____

Signed: _____ Date Signed: _____
(Parent, Legal Guardian or Custodian of the Patient, if appropriate)

Phone: (____) ____ - _____

Address: _____

City: State/Province: Zip/Postal Code: _____

1690 Stone Village Lane NW, Suite 910, Kennesaw, GA 30152

Mailing Address: 1635 Old 41 Highway NW, Suite 112-276, Kennesaw, GA 30152

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