



REQUEST FOR RELEASE OF RECORDS

Date: _____

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

Dr. Robert N. Pickron (Pickron Orthodontic Care)
3294 Medlock Bridge Road, Suite A-200 • Norcross, GA 30092
Fax: 770-446-5511

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 and copies of **all dental records, medical records and financials (including my contract)**.

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: Zip Code: _____

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

Phone: (____) ____ - _____

Address: _____

City: State: Zip Code: _____

Date Requested: _____ Date(s) Faxed: _____ Date Received: _____