770-778-8210 | www.farrarortho.com

Date: __________

REQUEST FOR RELEASE OF RECORDS

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

Dr. _______________________
Address: ____
City: State/Province: Zip/Postal Code: _____________________________________
to provide
William K. Farrar Jr., DDS, MDS
Mailing Address: 1635 Old 41 Hwy NW, Suite 112-276
1690 Stone Village Ln NW, Suite 900, 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 and medical records.

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

Signed: ____ Date Signed: _______
(Patient)
S.S.N./S.I.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: ____