Stapleton Children's Dentistry

2373 Central Park Blvd., Suite 305
Denver CO 80238
Phone: 303-399-5437
Fax: 303-399-5445

Records/X-ray Release Form

I _____ Authorize Stapleton Children's Dentistry, to release dental records and x-rays

To:_____

Address:_____

Phone:_____ Email:_____

For Patient(s)_____ DOB:_____

_____ DOB:_____

_____ DOB:_____

Patient/Guardian Signature_____ Date_____

We value your opinions. Please let us know why you are requesting records.

- Insurance
- Moving
- Age of Children
- Other (Please explain below)

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I agree that the Stapleton Children's Dentistry may communicate with me electronically at the email address provided. I am aware that there is some level of risk that a third party might be able to read unencrypted emails.

*I am responsible for providing the dental practice any updates to my email address.

*I can withdraw my consent to electronic communications by calling 303-399-5437

Email Address (PLEASE PRINT CLEARLY):

_____@_____

Parent/Guardian Signature_____ Date_____