

# Record Release Form

Date: \_\_\_\_\_

I give my permission to Sweet Smile Orthodontics PC and Dr. Tony Tyan to provide any and all information with respect to the orthodontic care of \_\_\_\_\_ (Patient's name) to my family/general dentist, pediatric dentist, and any other dental or medical specialists who may be involved in the treatment of above mentioned patient.

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.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed \_\_\_\_\_ Date Signed \_\_\_\_\_  
(Patient)

Signed \_\_\_\_\_ Date Signed \_\_\_\_\_  
(Parent, Legal Guardian Custodian of the Patient if appropriate)