AUTHORIZATION TO FORWARD OR REQUEST RECORDS

_____ _____
Patient name Date of birth

_____ _____
Patient name Date of birth

_____ _____
Patient name Date of birth

FORWARD RECORDS

I authorize Nordstrom or Wee Care Pediatric Dental to forward my dental records:

To: _____

Address: _____

Phone: _____ Fax: _____

E-mail:_____@_____._____

When: (circle one) ASAP (1 week minimum) Upon notification

REQUEST RECORDS

I authorize Nordstrom or Wee Care Pediatric Dental to request my dental records:

To: _____

Address: _____

Phone: _____ Fax: _____

E-mail:_____@_____._____

Scheduled appointment on: _____

_____ _____
Signature of authorized person Date

_____ _____
Printed name Relationship to patient

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