Request for Release of Records

Date: _____

I, _____ hereby request and give my permission to
(Patient, Parent or Guardian)
Dr. Klepacki to provide any and all information which he may request with respect to the orthodontic care of _____.
(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 agree to pay the cost of duplicating any records. A photocopy of this release will be as effective and valid as the original.

Signed_____ Date Signed_____
(Patient, Parent or Guardian)

Dr. Klepacki and Associates, Ltd
105 E. First St.
Hinsdale, IL 60521
630-325-0100