



1235 Indian Trail Road  
Suite 300 Norcross, GA 30093  
Tel: 770-837-9431

Parent Name, Address and Tel: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name and Date of Birth/s of the patient/patients:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

I am writing to request a copy of the dental records for my child/children listed above to be sent to the office of:

Office Name and Address: Please include their email and fax number

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Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CONFIDENTIALITY NOTICE:** The information in this message is confidential and may be legally privileged. It is intended only for the individual or entity named above. If you are not the intended recipient, you are hereby notified that any use, dissemination or copy of this facsimile is strictly prohibited. If you have received this facsimile in error, please notify the sender by telephone immediately. Thank you.