KEMIE D. HOUSTON, D.D.S., M.S.,P.C.
125 INVERNESS DRIVE EAST, SUITE 300
ENGLEWOOD, COLORADO 80112
303-779-5306/FAX 303-779-1822

AUTHORIZATION TO RELEASE DENTAL/MEDICAL RECORDS

The execution of this form does not authorize the release of information other than that specifically described below

To: _____

Patient: _____ DOB: _____

Release to: **Kemie D. Houston DDS MS PC**

Mailing Address: 125 Inverness Drive East, Suite 300 Englewood, CO 80112

Phone Number: 303-779-5306

I request and authorize the above named doctor or health care provider to release the information specified below to the organization, agency, or individual named on this request. Thank you

INFORMATION REQUESTED

_X_ Copy of dental treatment record
_X_ Email current x-rays to: kidsmilehigh@yahoo.com

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED

__X__ Transfer of records

My child/children have their appointments scheduled on:

_____ **at** _____

AUTHORIZATION
I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge.

_____
Parent/responsible party **print name** **Date**

_____
Parent/responsible party **signature** **Date**