AUTHORIZATION TO OBTAIN RECORDS

I Hereby Authorize:

Everglades Pediatric Dentistry
Dr. Melissa Kindell, D.M.D
2029 HWY 441 North
Okeechobee, FL 34972
863-357-7338 Phone
863-357-7342 Fax

To Obtain Records From:

_____

_____

_____

Records we are requesting: _____

1. _____
   Last Name First Name MI DOB

2. _____
   Last Name First Name MI DOB

3. _____
   Last Name First Name MI DOB

Parent / Guardian Signature

X_____ Date: _____

Parent / Guardian Address: _____

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