

Talbot A. Sklar, D.D.S.

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Records Release Form

I, _____ . hereby

authorize Talbot A. Sklar, D.D.S. to provide copies of my/my child's dental records and/or x-rays with respect to any dental care and treatment for transfer to:

(Party to Whom Records Will Be Sent)

(Address)

(City, State, Zip)

I understand that the specific type of information to be disclosed includes a detailed report of examinations, findings, treatments, prognosis and copies of any and all other records, including x-rays, which pertain to me/my child.

This consent is effective until such date as I can cancel this consent. I understand that information obtained as a result of this consent may be used after the cancellation date.

Signed: _____ **Date:** _____
(Patient)

Signed: _____ **Date:** _____
(Parent, Guardian If Patient is Under Age 18)

Address: _____
