dental buddies of Vero Beach
Schwibner & Associates

Complete Pediatric Dental Care
For Complete Health

Patient Record Release

Date: _____

I, _____, authorize the following Doctor
(Patient's Name)

_____
(Doctor's Name)

To release my records to:

❑

Name: Dental Buddies of Vero Beach
Address: 3755 7th Terrace, Suite 303
Vero Beach, Fl. 32960
Phone: 772.772.6888
Fax: 772.772.6889
E Mail: Office@verobeachpediatricdentist.com

❑ Other

Name: _____
Address: _____
_____
Phone: _____
Fax: _____
E Mail: _____

_____
(Patient/Parent or Guardian Signature