ROBERT L. EDMONSTONE, D.D.S.
PEDIATRIC DENTISTRY
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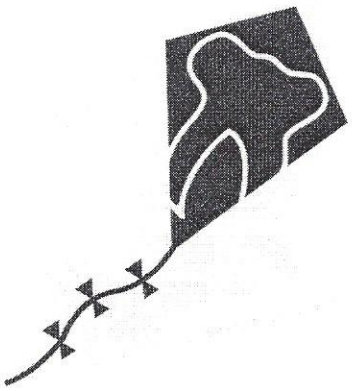

Date:_____

AUTHORIZATION TO RELEASE DENTAL INFORMATION

I hereby authorize the offices of Robert L Edmonstone, DDS or

_____
Name and address of individual or entity

to release any dental/medical information for _____
child/children's name(s)

to the following: **Robert L Edmonstone, D.D.S**
Pediatric Dentistry
251 Main Street
Old Saybrook, CT 06475
admin@edmonstonedental.com

or

_____
Name and address of individual or entity

I understand that this transfer may consist of treatment summaries and recent documents only unless specified.

_____
Relationship to Child

_____ _____
Print Name **Signature**