



PEDIATRIC  
Dental Specialists

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## Records Release Authorization

I respectfully request that you release the complete dental history records that you have on file concerning the treatment of the patient listed below. Please forward any digital images in jpeg format to: [info@pdssmiles.com](mailto:info@pdssmiles.com)

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Records Released from Doctor: \_\_\_\_\_

Telephone#: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent / Legal Guardian

\_\_\_\_\_  
Date

Sincerely,  
Dr. David H. Brantley  
Dr. John W. Spratling  
Dr. Will Brantley