

**AUTHORIZATION TO RELEASE
DENTAL/SKELETAL X-RAYS/TREATMENT
NOTES/PHOTOGRAPH OF MISSING
JUVENILE**

NAME OF MISSING JUVENILE	
REPORTING AGENCY AND CASE NUMBER	REPORTING PARTY

Under California Penal Code Section 14212, the family or next-of-kin of any person under the age of 18 years who is reported missing and has not been located within 30 days may authorize the release of the dental or skeletal X-rays, or both, and treatment notes and a recent photograph of the missing juvenile. This release form **shall** be taken to the dentist, physician and surgeon, or medical facility of the missing person to obtain the release of the dental or skeletal X-rays and treatment notes. The dental or skeletal X-rays, or both, **shall** be released to the person presenting this request. The person to whom the records are released **shall**, within 10 days, bring those records to the police or sheriff's department or other law enforcement agency having jurisdiction over the investigation.

If your missing juvenile is found, please notify the law enforcement agency **immediately**.

AUTHORIZATION

I am a family member or next-of-kin of the above-named missing juvenile and I hereby authorize the release of all dental or skeletal X-rays and treatment notes to assist law enforcement agencies in locating the above-named missing juvenile. I also consent to the release of the above-named missing juvenile's photograph, physical description, and circumstances surrounding the disappearance. This information may be used by the Department of Justice for inclusion in missing children bulletins and posters which will be distributed throughout California to law enforcement agencies, elementary and secondary schools, state buildings, appropriate roadside rest areas, and other parties determined appropriate by the Department of Justice to assist in locating the missing juvenile, including the Attorney General's Web Site at www.caag.state.ca.us.

NAME OF DENTIST			
ADDRESS			
CITY	STATE	ZIP	TELEPHONE NUMBER ()
NAME OF PHYSICIAN, SURGEON OR MEDICAL FACILITY			
ADDRESS			
CITY	STATE	ZIP	TELEPHONE NUMBER ()
SIGNATURE OF FAMILY MEMBER			
RELATIONSHIP TO MISSING JUVENILE			DATE
ADDRESS			
CITY	STATE	ZIP	TELEPHONE NUMBER ()

**AUTHORIZATION TO RELEASE
DENTAL/SKELETAL X-RAYS
AND TREATMENT NOTES OF
MISSING ADULT**

NAME OF MISSING ADULT	
REPORTING AGENCY AND CASE NUMBER	REPORTING PARTY

Under California Penal Code Section 14212, the family or next-of-kin of any person reported missing and has not been located within 30 days may authorize the release of the dental or skeletal X-rays, or both, and treatment notes of the person reported missing. This release form **shall** be taken to the dentist, physician and surgeon, or medical facility of the missing person to obtain the release of the dental or skeletal X-rays and treatment notes. The dental or skeletal X-rays, or both, and treatment notes **shall** be released to the person presenting this request. The person to whom the records are released **shall**, within 10 days, bring those records to the police or sheriff's department or other law enforcement agency having jurisdiction over the investigation.

If the missing adult is found, please notify the law enforcement agency **immediately**.

AUTHORIZATION

I am a family member or next-of-kin of the above-named missing adult and I hereby authorize the release of all dental or skeletal X-rays and treatment notes to assist law enforcement agencies in locating the above-named missing adult. I also consent to the release of the above-named missing adult's photograph, physical description, and circumstances surrounding the disappearance. This information may be used by the Department of Justice for inclusion in missing person bulletins and posters which will be distributed throughout California to law enforcement agencies, state buildings, appropriate roadside rest areas, and other parties determined appropriate by the Department of Justice to assist in locating the missing person, including the Attorney General's Web Site at www.caag.state.ca.us.

NAME OF DENTIST			
ADDRESS			
CITY	STATE	ZIP	TELEPHONE NUMBER ()
NAME OF PHYSICIAN, SURGEON OR MEDICAL FACILITY			
ADDRESS			
CITY	STATE	ZIP	TELEPHONE NUMBER ()
SIGNATURE OF FAMILY MEMBER			
RELATIONSHIP TO MISSING ADULT		DATE	
ADDRESS			
CITY	STATE	ZIP	TELEPHONE NUMBER ()