

DENTAL HISTORY INFORMATION

\_\_\_\_\_  
Missing Person's Name

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

\_\_\_\_\_  
Investigating Agency's Name

\_\_\_\_\_  
Agency Case Number

\_\_\_\_\_  
Investigating Officer's Name

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The information requested on these forms will be used to assist in the identification process. Your cooperation in completing these forms is appreciated.

AUTHORIZATION TO RELEASE DENTAL RECORDS

I am the parent/legal guardian/next of kin of the above-named missing person and I hereby authorize the release of medical records to assist criminal justice agencies in locating the missing person.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, and ZIP

\_\_\_\_\_  
Telephone Number

1-800-368-5878  
FBI  
for Characteristics  
of Characteristics