

Pediatric Dentistry

Authorization for Release of Protected Health Information

Please complete this form thoroughly. You or your dependent's dental records cannot be released until this form is completed and signed by the patient (or if under 18 their parent or legal guardian).

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize PEDIATRIC DENTISTRY to release the following identifiable health information:
(Please specify if you do not need all records released.)

_____ PANORAMIC / PERIAPICAL X-RAY(S)

_____ Oral Surgeon

_____ Orthodontist

_____ ALL DENTAL RECORDS

_____ Leaving Practice

*Reason for Leaving: _____

PLEASE PRINT

Mail to: _____

Address: _____

City: _____ State: _____ Zip: _____

This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date.
Additional authorization for disclosure beyond the recipient is required.

Signature of Patient or Guardian: _____

Date: _____