Authorization to Release Dental/Medical Information

Patient Name: _____ Date of Birth: _____

Release to (include name and physical address or email address based upon desired mode of transfer): _____

_____

_____

Information Requested

- ☐ Copy of dental treatment record
- ☐ Copy of current dental x-rays

Purpose or Need for Requested Information

- ☐ Transfer of care
- ☐ Specialty Referral
- ☐ Second Opinion
- ☐ Other

Authorization

I request and authorize Dentistry for Children to release the information specified herein to the organization, agency, or individual named for the purpose of patient care. I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Re-disclosure of my medical records by those receiving the above authorized information may not be accomplished without my further written consent.

Parent/Responsible Party (print): _____

Parent/Responsible Party (signature): _____

Date: _____

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