The Center for PEDIATRIC Dental Care & Orthodontics

Pediatric & Adolescent Dentistry and Orthodontics for Children and Adults

AUTHORIZATION TO RELEASE DENTAL INFORMATION

The execution of this form does not authorize the release of information other than specifically described below.

Patient Name: _____ Release to: _____

Date of Birth: _____ Address: _____

INFORMATION REQUESTED

_____ Summary of Dental Chart

_____ E-mail Most Recent Dental X-rays

Other (please describe): _____

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED

_____ Transfer of Records

_____ Additional Consult

Other: _____

AUTHORIZATION: I certify that this request has been made, and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at anytime, except to the extent that action has already been taken to comply with authorization. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure.

Authorized Signature: _____ Date: _____

Relationship to Patient: _____

OFFICE USE ONLY

Date release requested: _____ Date records released: _____

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