REQUEST FOR RELEASE OF RECORDS / RADIOGRAPHS

Name of Patient: _____ Date of Birth: _____
Patient's Address: _____

Parent/Dental office/Medical office to receive information:

Name: _____
Address: _____
Email: _____ Phone: _____

Reason for Records Release: _____

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address above. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. This authorization shall be in force and effect until the requested items have been delivered or the information has been reviewed by the parent.

Signature of Parent / Legal Guardian: _____
Print Name of Parent / Legal Guardian: _____
Relationship to Patient: _____
Date: _____

* * * * * * * * * * * * * *

FOR OFFICE USE ONLY

Date Sent: _____ VIA: ___ Email ___ Mail ___ Pickup

Print Name of Employee: _____

Signature of Employee: _____