HIPAA

MEDICAL/DENTAL

RELEASE FORM

Parent's Name: _____ _____ **Date of Birth:** ___ /____/_____
First *Last*

Child's Name: _____ _____ **Date of Birth:** ___ /____/_____
First *Last*

Child's Name: _____ _____ **Date of Birth:** ___ /____ /_____
First *Last*

Email Address: _____

TYPE OF INFORMATION

☐ Itemized Bill ☐ Medical/Dental Record ☐ X-Rays ☐ Progress Notes

RECORD RELEASE

Record is to be released to the following individual or office:

Name: _____ Phone #: _____

Delivery Method: ☐ Electronic or ☐ Mail (USPS) Email: _____

Mailing Address: _____ City _____State: ____Zip _____

REASON FOR REQUEST

☐ Continued Dental Care ☐ Legal Purposes ☐ Insurance Purposes ☐ Personal Interest

CONSENT

Name : _____ Driver's License #_____

Dental Disclaimer: I understand that the dental record released in agreement to this authorization could contain information concerning drug related conditions and /or blood borne infectious diseases which are subject to federal and /or state restrictions on disclosure. I understand that if the person or organization that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by the regulations. I hereby declare that I have read and fully understand the above statement and consent to the release of medical/dental record for the purpose and extent stated above.

INSTRUCTIONS: Please sign, then facsimile along with a copy of driver's license to (407) 770 0171
or email to info@pediatricdentalcareorlando.com