Pediatric Dentistry, P.C.

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL RECORDS

REGARDING: ____________________________________ DOB___________________

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To Whom It May Concern:

I hereby authorize Pediatric Dentistry, P.C. to release and exchange the following information regarding my family.

List Information to be released: ______________________________________

To: ____

Address: ____

____

Phone Number(s): ____

Email Address: ____

For the purpose of: ____

(Treatment Planning, Education Training, Etc.)

1. I hereby consent to the release of the above information. I understand such information cannot be released without my specific consent.
2. I have read the above and fully understand its contents and have asked questions about anything that was not clear to me. I am satisfied with the answers I have received.
3. This authorization is valid for one year from the date below unless revoked in writing.

____

(Signature) (Date)

Records obtained as authorized by this for will be maintained in accordance with the federal confidentiality regulation title 42 of the federal register which prohibits re-disclosure. The consent form meets requirements of ORS170.505 and public law 93-282.