Smiling with Love
Pediatric Dentistry

5004 Ferrell Pkwy, Ste 104
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REQUEST FOR RELEASE OF DENTAL RECORDS

Authorization for release of protected health information patient

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1. Patient(s) Information

- **Full Name:**_____
  _____
- **Date of Birth:** _____
- **Phone Number:**_____
- **Email Address:**_____
- **Address:** _____
  _____

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2. Releasing Dental Office (Current Provider)

- **Practice/Doctor Name:** _____
- **Phone Number:** _____
- **Fax Number:** _____
- **Address:** _____

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3. Receiving Party (Where Records Will Be Sent)

- **Name/Organization:** _____
- **Attention (if applicable):** _____
- **Phone Number:** _____
- **Fax Number:** _____
- **Email Address:** _____
- **Address:** _____
- Date Range (if applicable):
  From: _____ To: _____

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4. Purpose of Request (Optional)

- ☐ Transferring to a new dentist
- ☐ Personal records

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- ☐ Insurance/Legal purposes
- ☐ Referral/Specialist care
- ☐ Other: _____

5. Authorization & Signature

I authorize the release of my dental records as indicated above. I understand this authorization is valid for 90 days unless revoked in writing. I understand that once the records are released, they may no longer be protected by HIPAA privacy regulations.

- **Signature of Patient or Legal Guardian:** _____
- **Printed Name:** _____
- **Date:** _____

If signed by someone other than the patient, state your legal authority:
☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Other: _____

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8. Office Use Only *(Optional Section)*

- Date Request Received: _____
- Identity Verified: ☐ Yes ☐ No
- Processed By: _____
- Records Released On: _____
- Notes:
