DOUGLAS S FRY, DDS PEDIATRIC DENTISTRY

REQUEST FOR RELEASE OF RECORDS/RADIOGRAPHS

Name of patient _____ Date of Birth _____

Patient's Address _____

Name, address, and email address of parent/dental office/medical office to receive information

_____

_____

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 OR LEGAL GUARDIAN _____

RELATIONSHIP _____

PRINT NAME OF PARENT OR LEGAL GUARDIAN _____

DATE: _____

FOR OFFICE USE ONLY:

Date sent: _____ via email mail pickup

Signature of employee: _____

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