AUTHORIZATION FOR RELEASE OF PATIENT RECORD INFORMATION FROM CARY PEDIATRIC DENTISTRY

Name of Patient: _____ Date of Birth: ___/____/____

Address of Patient: _____
Number & Street Apt.

_____
City State Zip

Reason for Transferring: _____

I hereby authorize Cary Pediatric Dentistry the right to

RELEASE TO: _____
(Name of doctor, hospital or dentist to RECEIVE information)

_____
(Street Address, City, State, Zip and Phone number)

_____
(Email address of doctor/office to RECEIVE digital x-rays)

the following information:_____

covering the period of care from _____ to _____

I understand I may revoke this consent at any time except to the extent that action has already been taken on it and that it will expire automatically ninety (90) days from the date below.

Cary Pediatric Dentistry, by releasing authorized information, is hereby relieved from all legal responsibility or liability for the release of the information described above to the extent indicated and authorized herein.

_____ _____
Parent or Legal Guardian Signature Date

540 New Waverly Place• Suite 300 • Cary, NC 27518 • Telephone: (919) 852-1322 • FAX: (919) 852-1230