CONSENT TO RELEASE PATIENT RECORD INFORMATION

Patient's Full Name: ____ Date of Birth: ________________

Patient's Address: ____
Number & Street City State Zip

Parent's Name: ____

I hereby authorize Durham Pediatric Dentistry & Orthodontics to **RELEASE** information to:

Name: ____
(Dentist, hospital, school or individual you want information **SENT** to)

Please send this information via:

- ☐ Fax: (Fax Number) ____
- ☐ Email: (Email address) ____
- ☐ Mail: (Address) ____
  Number & Street City State Zip

Information to Be Released:

- ☐ Bite-Wing Radiographs
- ☐ Panoramic Radiographs (Panorex)
- ☐ Pediatric Dental Treatment History
- ☐ Periapical Radiographs (P.A.)
- ☐ Cephalometric Radiograph (Ceph)
- ☐ Orthodontic Casts
- ☐ Other: ____
  ____

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.

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

____ ________________________
Signature of Parent Date

____ ________________________
Signature of Witness Date