CONSENT TO RECEIVE PATIENT RECORD INFORMATION

Patient's Full Name: _____ Date of Birth: _____

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

Parent's Name: _____ Date of Birth: _____

I hereby authorize: _____
(Dentist, hospital, school or individual SENDING information)

To **RELEASE** information to:

Durham Pediatric Dentistry & Orthodontics
121 W. Woodcroft Parkway
Durham, NC 27713

Office: (919) 489-1543
Fax: (919) 489-2892
Email: info@DurhamPDO.com

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