CHARLESTON PEDIATRIC DENTISTRY
INFANTS | CHILDREN | YOUNG ADULTS

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PATIENT INFORMATION AND RELEASE AUTHORIZATION

I hereby authorize **Charleston Pediatric Dentistry** to ☐ release ☐ obtain information contained in my child's patient records.

Child's name _____

Address _____

Date of Birth _____

Information is to be released to:

Name _____

How you would like to receive records (please ***choose one*** option)

☐ Fax _____ ☐ email _____

☐ Mail (please provide mailing address) _____

_____

The purpose of disclosure _____

I understand that this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance to this consent.

The facility, its employees and officers are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Relationship to patient _____ Printed Name _____

Signature _____ Date _____