DISCOVERY PEDIATRIC DENTISTRY

1700 California Street, Suite 200, San Francisco, CA 94109-4582
Tel (415) 441-7766 Fax (415) 441-1919
DiscoveryPD@yahoo.com (www.PediatricDentistSF.com)

Emily H. Wang, DDS
Ignatius Nate Gerodias, DDS
Melanie Perea-Corkish, DDS, MS

RECORDS RELEASE FORM

Please release dental records pertaining to ____ DOB: ________________
(name(s) of patient(s))

or copies of such, and I request that they be transferred to:

Name/Office: ____
Address: ____
City/State/Zip: ____
Phone: (______) ____________________ Fax: (______) ______________
Email: ____

**** Please note: If you are requesting a copy of your child(ren)'s dental records, the most recent set of notes and x-rays will be provided as a courtesy. If requesting additional past records, a processing fee will be applied for the request. Fees vary pending the volume of records requested. Please allow 5-10 processing days to complete your request.**

I hereby release **Discovery Pediatric Dentistry** from any and all liability related to disclosure of confidential or privileged information. Furthermore, I recognize that email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by, unauthorized third parties.

DURATION — This authorization shall become effective immediately and shall remain in effect for one (1) year from the date of signature, unless a different date is specified here _________.

REVOCATION — This authorization is also subject to written revocation by the parent, legal guardian, or patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

REDISCLOSURE — I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law

A copy of this authorization is as valid as the original. Parent, legal guardian, or patient has a right to a copy of this authorization

Requested by: ☐ Patient ☐ Parent/legal guardian ☐ Personal representative* of the patient

*Guardian or conservator of the patient, or beneficiary or representative of a deceased patient. Photo ID and other proof of representation may be required.

If requestor is not the patient, please complete below:

☐ Same as Above ☐ Contact info on file

Name: ____
Address: ____
City/State/Zip: ____
Home Phone: (______) ____________________ Cell: (______) ______________

Signature: ____ Date: ____________________
Name of Parent, Patient or Legal Guardian *(authorized to consent for patient)*

Please send records by:

☐ Via email ☐ Mail ☐ I will pick up

For office use only

Records to be released: ☐ Dental Records ☐ X-rays ☐ Both ☐ Pano only

Person making request? ☐ Mother ☐ Father ☐ Patient ☐ Legal Guardian ☐ Doctor's Office
Staff Name: ________________

☐ **Telephone request of dental records** Date: ____________ Time: ____________ Request Taken by: ____________________

Will chart go to inactive ☐ Yes ☐ No

Fee Charge ☐ Yes ☐ No If so, total fees:______________Doctors Initials: _______ Date _________