9901 Fairfax Blvd., Fairfax, VA 22030 P: 703.383.3434 F: 703.383.3113
6120 Brandon Avenue, Suite 114, Springfield, VA 22150 P:703.992.7100 F:703.992.7137

AUTHORIZATION TO RELEASE DENTAL INFORMATION

Patient's name: _____ **Date of Birth:** _____

Name: _____ **Relationship to Patient:** _____

I request and authorize Pediatric Dental Care to release the information specified below to (select one):

____ 1. me directly.

____ 2. the following dental office directly:

Name of Dental Practice: _____

Address: _____

Phone: _____ Fax: _____

FORM OF RECORDS: _____Paper ____Digital Files on CD ($10 fee applied for service and materials)

I understand that the information to be released includes information regarding the following condition(s):

INFORMATION REQUESTED:

_____Copy of complete dental chart/ dates covered: _____

_____Copy of dental x-rays / dates covered: _____

_____All treatment rendered / dates covered: _____

_____Others (e.g. models—describe) _____

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:

_____Transfer of Records _____Second Opinion

_____Other, please explain_____

Your child's record has to be carefully reviewed by a dentist before it is released. Please allow 3 to 5 business days to complete your request.

AUTHORIZATION: *I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge.*

Parent Signature: _____**Date:**_____

PDC staff: _____**Date:** _____

Approved by: _____**Date:** _____