Authorization to Release Dental Records

I authorize Center For Pediatric Dentistry, Dr. Lee Baker, to release dental records for my children listed below:

Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____

To:
Name: _____
Address: _____
City: _____ State: _____ Zip Code:_____
Telephone: _____ Fax:_____
E-mail: _____

Any records provided via e-mail to another dental office will be sent securely through send inc to safeguard your protected health information.

You have the option to request records be sent to you so you can then forward them to another dental office as needed. These records can be sent securely through send inc or through regular e-mail. Secure e-mail protects your personal information from any unauthorized access but must be retrieved and downloaded within 7 days or they will expire. The confidentiality of regular e-mail cannot be guaranteed. If you are concerned about confidentiality, we recommend secure e-mail.
I request records be sent to me at _____. Secured ____ unsecured_____

Signature: _____ Dated: _____
Relationship to patient: _____

Authorization Expires One Year After It Is Signed

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