AUTHORIZATION FOR RELEASE OF RECORDS

I, _____ (parent/guardian name) give permission to Pediatric Dentistry and Orthodontics of Midland Park, LLC to release all records and current x-rays for the following child/children:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Reason for Transferring: _____

I authorize the records be sent by mail / email (circle one) to:

Name :_____

Address:_____

Address:_____

Phone #: _____

Email: _____

Date of upcoming appointment(s) with new dentist: _____

Parent Signature: _____

Date: _____

Parent Cell Phone: _____

Parent Email: _____

In consideration of such disclosure on the part of Pediatric Dentistry and Orthodontics, LLC, I hereby release them from any liability arising from such disclosure.

I UNDERSTAND THAT IF THESE RECORDS ARE TRANSFERRED BY EMAIL THAT THE HEALTH INFORMATION MAY BE TRANSMITTED UNECRYPTED AND THEREFORE THERE IS A RISK THAT A THIRD PARTY MAY INTERCEPT THIS INFORMATION. I ACCEPT THIS RISK AND REQUEST THAT THE HEALTH INFORMATION BE TRANSFERRED BY UNENCRYTED EMAIL.