Charlottesville Pediatric Dentistry

# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to (i.e., Dental Office or Doctor's Office):

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

PLEASE FAX TO:
Charlottesville Pediatric Dentistry
1620 Timberwood Blvd, Suite 201, Charlottesville, VA 22911
O: 434-975-7336 or F: 434-975-7338