CZARKOWSKI PEDIATRIC DENTISTRY
RELEASE OF INFORMATION

1927 BROAD RIPPLE AVE PHONE: 317-964-0900 FAX: 317-602-2474

)ATE:_____ PRINTNAME OF PARENT/GUARDIAN COMPLETING FORM:_____

'lease check the following options:

❑ I hereby authorize CZARKOWSKI PEDIATRIC DENTISTRY. to ***release*** the following information from the medical / dental record(s) of:

❑ **CHILD'S NAME:** _____ **DATE OF BIRTH:**_____

❑ I hereby authorize CZARKOWSKI PEDIATRIC DENTSITRY. to ***request*** the following information from the medical record(s) of:

PLEASE LIST NAMES OF THE INDIVIDUALS TO RELEASE MEDICAL/DENTAL INFORMATION REGARDING CHILD LISTED ABOVE.

NAME_____ RELATIONSHIP_____

NAME:_____ RELATIONSHIP_____

NAME:_____ RELATIONSHIP_____

NAME:_____ RELATIONSHIP_____

Information to be released: **ALL** or Specific Dates_____
_____Notes from Office Visit
_____Treatment Plan
_____Other-Please List _____

Records are to be:
❑ Requested from _____
❑ Sent to

NAME_____

COMPANY_____

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE _____ FAX _____

Purpose of Disclosure:
___ Attorney/Legal
___ Continued Patient Care
___ Personal Use
___ Commercial Insurance
___ Other (Specify)

_____
_____
_____

(Copying Fee: $0.50 per page, $5.00 minimum)

I understand that such medical records may contain information regarding psychological, drug, and /or alcohol conditions, and /or diagnosis, treatment and care of sexually transmitted diseases or complications related to sexually transmitted diseases, including but not limited to HIV testing and results. I hereby authorize the release of such medical records pursuant to this authorization for release or request of medical records, and waiver confidentiality provisions pertaining to this release. I understand letters, correspondences, and copies of medical records from other health care providers will not be released.

Specification of the date, event, or condition upon which this consent expires: I understand that this consent is revocable, except to the extent that action has already been taken in reliance thereof. Request for revocation of this authorization must be in writing and presented to the Medical Records representative of Czarkowski Pediatric Dentistry. This authorization will expire (i) after one year, (ii) after the disclosure is made, or (iii) the date specified here: _____ to accomplish to purpose of the disclosure state above

The employees and dentist(s) are hereby released from any legal responsibility or liability for the release or request of the above information to the extent indicated and authorized herein. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected after release from the office of Czarkowski Pediatric Dentistry.. I understand that authorizing this disclosure of health information is voluntary.

Signature of Parent/Legal Guardian_____ Date_____

If Legal Representative, State Relationship_____