AUTHORIZATION FOR RELEASE OF PATIENT RECORD INFORMATION

Name of Patient: _____ Patient's Date of Birth: _____

Patient's Parent: _____ Home Phone: _____

Work Phone: _____

Patient's Mailing Address: _____

Reason for Release of Records: _____

_____

How do you rate our customer service? Poor Fair Good Excellent (Circle one)

How would you rate our dental care? Poor Fair Good Excellent (Circle one)

How may we have serviced you better? _____

_____

I hereby authorize Dr. Amy C. Davidian the right to

RELEASE TO: _____

(Name of doctor, hospital or dentist to RECEIVE information)

The following information: _____

Covering the period of care from _____ to _____

☐ **Send the information electronically. Email address:** _____

☐ For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

I understand I may revoke this consent at any time except to the extent that action has already been taken on it and that it will expire automatically ninety (90) days from the date below.

Dr. Amy C. Davidian by releasing authorized information, is hereby relieved from all legal responsibility or liability for the release of the information described above to the extent indicated and authorized herein.

_____ _____

(Parent or Legal Guardian Signature) (Date)

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