



## **Authorization to Release Health Information**

I authorize Preston Corners Pediatric Dentistry to release my child's records/applicable radiographs to the office of:

Office Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Patient Name(s): \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_ DOB: \_\_\_\_\_

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient(s): \_\_\_\_\_

*\*Please return this form to our office by email at **info@PediatricDentistCaryNC.com***