CHARLESTON PEDIATRIC DENTISTRY
INFANTS | CHILDREN | YOUNG ADULTS

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PATIENT INFORMATION AND RELEASE AUTHORIZATION

1. I hereby authorize **Charleston Pediatric Dentistry** to ☐ release ☐ obtain information contained in my child's patient records.

   Child's name _____

   Address _____

   _____

   Date of Birth _____

2. Information is to be released to:

   Name _____

   Fax _____ email _____

   Mail _____

3. The purpose of disclosure _____

   _____

4. I understand that this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance to this consent.

5. The facility, its employees and officers are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Relationship to patient _____

Printed Name _____

Signature _____ Date _____