AUTHORIZATION AND RELEASE OF RECORDS

I, ____ (parent/guardian name) give permission to Pediatric Dentistry and Orthodontics of Midland Park, LLC to release all records and current x-rays for the following child/children:

Name: ___________________________________ Date of Birth: ________________

Name: ____________________________________ Date of Birth: ________________

Name: ____________________________________ Date of Birth: ________________

I authorize the records be sent by mail / email (circle one) to:

Name :____

Address:____

Address:____

Phone #: ____

Email: ____

Date of upcoming appointment(s) with new dentist: ________________________

Parent Signature: ____

Date: ________________________________

Parent Cell Phone: __________________________________

Parent Email: _______________________________________

In consideration of such disclosure on the part of Pediatric Dentistry and Orthodontics, LLC, I hereby release them from any liability arising from such disclosure.

I UNDERSTAND THAT IF THESE RECORDS ARE TRANSFERRED BY EMAIL THAT THE HEALTH INFORMATION MAY BE TRANSMITTED UNECRYPTED AND THEREFORE THERE IS A RISK THAT A THIRD PARTY MAY INTERCEPT THIS INFORMATION. I ACCEPT THIS RISK AND REQUEST THAT THE HEALTH INFORMATION BE TRANSFERRED BY UNENCRYTED EMAIL.