BLACK HILLS pediatric DENTISTRY

Where Bright Smiles Begin

Pediatric Dentists: Brent J. **Bradley**, DDS*; Kelli J. **Jobman**, DDS*; Karli M. **Williams**, DDS*; William J. **Donhiser**, DDS;
Adolescent & General Dentists: Jeffrey P. **Godber**, DDS; Thomas A. **Schmanski**, DDS

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____

DoB: _____ SSN#: _____

Address: _____

_____

Other family included: _____

_____

I hereby authorize _____ to release information from my child(ren) dental records **to**:

Black Hills Pediatric Dentistry
700 Sheridan Lake Road
Rapid City, SD 57702

(605) 341-3068
Fax: 605-341-5757
E-mail: *info@bhpdentistry.com*

Reason for Release: ☐ Changing Dentists ☐ Legal ☐ Insurance ☐ School

☐ Consultation / Second Opinion Other: _____

_____

_____

I understand if the health record includes information relating to behavioral or mental health care, treatment for alcohol and/or drug abuse, sexually transmitted disease, Hepatitis B or C, Acquired Immunodeficiency Syndrome (AIDS) or human immunodeficiency virus (HIV), it will be included in this release of records.

AUTHORIZATION: I certify that all the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time by submitting in writing, except to the extent that action has already been taken to comply with it. Without my express revocation, this authorization will **expire in 180 days** from the date. A faxed copy of this authorization may be utilized with the same effectiveness as the original unless otherwise noted in writing.

RE-DISCLOSURE: I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal privacy laws or regulations.

Parent / Legal Guardian _____ Date _____

*owner