Pediatric Dentists:
Brent J. Bradley DDS*
Kelli J. Jobman DDS*
Karli M. Williams DDS*
Stephany P. Liu DDS
(*Owner)
General Dentist:
Carla L. Heino DDS

AUTHORIZATION FOR RELEASE OF INFORMATION:

☐ **FROM BHPD** ☐ **TO BHPD**

Name: _____ Ph: (____) _____

Address: _____ Fax: (____) _____

_____

City/State/Zip: _____ E-mail: _____

Patient(s) Name: _____ DoB: _____

Patient(s) Name: _____ DoB: _____

Patient(s) Name: _____ DoB: _____

Covering the date(s) of service: FROM _____ TO _____

Reason for Release: ☐ Changing Dentists ☐ Legal ☐ Insurance ☐ School
☐ Consultation/2nd Opinion Other: _____

A parent or legal guardian may provide the authorizing signature if the patient is a minor.

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 **SIGNATURE** DATE

RELATIONSHIP TO PATIENT: ____ PARENT ____ LEGAL GUARDIAN
____ OTHER _____

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