

Pediatric Dentistry



Compassionate care for children, adolescents & those with special needs
Vernon J. Adams Jr., DMD & Jonathan M. Hurng, DDS, MPH

Authorization for Release of Medical Information & Authorization for Use/Disclosure of Protected Health Information

I hereby authorize **Pediatric Dentistry of Palo Alto, 325 Sharon Park Dr. Ste. D3, Menlo Park, CA 94025, (650) 321-6448**

Recipient

To disclose to (printed name of recipient):

Address:

City, State, Zip, Telephone & **Forwarding Email (required):**

Patient

Name of Patient:

Date of Birth (MM/DD/YYYY):

Information to be disclosed

Check the box and initial to specify which type of information is to be disclosed:

☐ Dental Records

☐ X-Ray Results

☐ Other (describe):

Initials:

Revocation: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be in effect upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Re-Disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Authorization Representative of Patient

Signature:

Name (Printed):

Relationship to Patient:

Date: