Drs. Dimock, Weinberg & Cherry, DDS

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RELEASE OF DENTAL RECORDS

I, _____, give permission to release copies of my child(s), _____, dental records for the purpose of patient care, from the office of *Drs. Dimock, Weinberg & Cherry DDS* to:

(name, address, fax, email of provider/persons receiving records)

_____
_____
_____
_____

I understand:

- I have the right to request a copy of this form after I sign it.
- If the person or organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- By releasing authorized information, the office of *Drs. Dimock, Weinberg & Cherry, DDS* is hereby relieved from all legal responsibility or liability.
- A ***copy*** of my records will be forwarded to the entity above. The original record remains the property of *Dimock, Weinberg & Cherry, DDS* and will be maintained by his office in accordance with North Carolina state laws.

Type of information to be disclosed:

□ Entire dental record
□ Current treatment plan
□ Financial/Insurance information
□ Copies of dental X-rays
□ Other: _____

_____ _____
Name of patient/patients Date of birth/births

_____ _____
Signature of Parent/Guardian Today's date

Office Use Only

Date records sent: _____

Transfer method: □ Email □ Mail □ Fax

Employee's Initials: _____