Doris Lin-Song, D.D.S., Inc.
Bergen James, D.D.S.
Jennifer Yu, D.D.S.
PEDIATRIC DENTISTRY

Release of Record

Patient Name_____ Date of Birth_____

I hereby authorize the use and disclosure of individually identifiable health information relating to the above patient as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Specific Description of Information to Be Released:

- Dental records including most recent radiographs, dental charting, and/or all other available charting information
- An explanation or summary of the requested records

Purpose for Disclosure:

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I authorize the following authorized person(s) or dental office to (1) receives and/or (2) make the requested use or disclosure of the above health information:

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I understand that I may revoke this authorization at any time by notifying the privacy official or Dr. Doris Lin-Song in writing. If I choose to do so, my revocation will not affect any actions taken by Doris Lin-Song, DDS, Inc. before receiving my revocation. I understand that this does not supersede the Notice of Privacy Practices.

Signature of Parent or Legal Guardian

_____ Date_____

***** The PHI (Personal Health Information) contained in this FAX/LETTER is HIGHLY CONFIDENTIAL. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to this patient. Any other use is a violation of Federal Law (HIPPA) and will be reported as such. *****

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