Doris Lin-Song, DDS
Bergen James, DDS
Jennifer Yu, DDS

one PARKER PEDIATRIC DENTISTRY

Release of Protected Health Information

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

Specific Description of Information to Be Released:

○ Dental records including a summary and most recent dental radiographs in JPEG digital format will be released.

Reason for requesting records:

____ Moving
____ 2nd Opinion
____ Going to a dentist closer to home
____ Other:_____

____ Graduate to adult dentist by One Parker
____ Transferring to a general/family dentist
____ Transferring to another pediatric dentist
____ Need to go in-network dentist due to insurance

To be released to:

Name: _____ E-mail address:_____

Address:_____ Phone # _____

_____

Please print your name: _____

Signature of parent/legal guardian: _____ Date: _____

- We will need a copy of your driver's license with the release.
- Please allow up to 7 business days for your request to be completed.

*** 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. ***

Office Use Only:
Request completed by: _____ Date Completed: _____
☐ Faxed to: (_____) _____
☐ E-mailed to: _____