Providence Specialty Pediatric Dental Clinic

Authorization for Release of Information

Patient: _____ DOB: _____

I / We hereby authorize mutual exchange of information between:

Providence Specialty Pediatric Dental Clinic
830 NE 47th Ave, Portland, OR 97213
t: 503.215.1056 f: 503.215.1059
opediatricdentalclinic@providence.org

And _____
Clinic Name/ Provider's Name

_____
Address *City, State* *Zip code*

_____
Phone # *Fax #*

The following information from my child's record(s): *(indicate nature or extent of information)*

_____

The above information is to be released for the following purpose only: _____

_____

I understand that I may revoke this authorization at any time, except to the extent that action has been taken based on this authorization before it is revoked.

If not revoked, this authorization will expire: _____
Specify date, event, or condition

I have read and understand this authorization. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received.

_____ _____
Parent/Legal Guardian *relationship to patient*

_____ _____
Witness *Date*