



Pediatric Dentistry for Children and Young Adults
 1700 California Street, Suite 200 San Francisco, CA 94109-4582
 Tel (415) 441-7766 Fax (415) 441-1919
 www.PediatricDentistSF.com
We handle with care ... and it shows

Fred C. Haeberlein, APDC
 Emily Wang, DDS
 Fred C. Haeberlein, DDS
 Melanie Perea-Corkish, DDS, MS

AUTHORIZATION FOR USE AND / OR DISCLOSURE OF PATIENT HEALTH INFORMATION

I _____, hereby authorize and request Fred C. Haeberlein, A.P.D.C.
Name of Parent / Legal Guardian / Patient

to release to _____
Name of Doctor, Institution, or Patient

- REQUEST FOR:** X-RAYS ONLY
 RECORDS
 BOTH
 PANO

Address _____ Unit # _____

City _____ State _____ ZIP _____

Medical / Dental records concerning findings and treatment of

Patient's Complete Legal Name Patient's Record No _____ Date of Birth _____

Specify the records to be disclosed Dental Medical

The recipient may use the health information authorized on this form for the following purposes

I hereby release Fred C. Haeberlein, A.P.D.C. from any and all liability related to disclosure of confidential or privileged information

DURATION This authorization shall become effective immediately and shall remain in effect for one (1) year from the date of signature, unless a different date is specified here _____

REVOCACTION This authorization is also subject to written revocation by the parent, legal guardian, or patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization

REDISCLASURE 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

A copy of this authorization is as valid as the original. Parent, legal guardian, or patient has a right to a copy of this authorization

Signature _____ Date _____
Name of Parent, Patient or Legal Guardian authorized to consent for patient

Address _____ Apartment _____
 _____ ZIP _____

TELEPHONE REQUEST FOR RELEASE OF PATIENT RECORDS

Date _____

Time _____

Will chart go to storage Yes No

Request Taken by _____

Fee Charge Yes No If so, total fees _____

WHO IS MAKING REQUEST? Parent Doctor's Office Patient

Records / X-rays are for

- Endodontics Oral Surgeon Orthodontics Oral Medicine
 Periodontics Prosthodontics Other DDS Medical Doctor