



Pediatric Dentistry for Children and Young Adults  
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 www.PediatricDentistSF.com  
*We handle with care ... and it shows*

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

*Fred Haeberlein, DDS    Emily Wang, DDS    Melanie Perea-Corkish, DDS, MS    Nate Gerodias, DDS*  
*Nicolas Bronzini, DDS    Cynthia Yee, DDS    Lydia Wong-Huey, DDS    Quinn Su, DDS*

**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 \_\_\_\_\_  
 or \_\_\_\_\_  
 request from \_\_\_\_\_  
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 Record No \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Patient's Complete Legal Name

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 \_\_\_\_\_

City \_\_\_\_\_ 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