

PIMA PEDIATRIC DENTISTRY  
MARC A. AUERBACH, D.D.S.  
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**AUTHORIZATION TO RELEASE PATIENT RECORDS  
FROM PIMA PEDIATRIC DENTISTRY**

This Authorization relates to: \_\_\_\_\_ (patient's name)

D.O.B.: \_\_\_\_\_  Male  Female

I, \_\_\_\_\_ the parent or legal guardian of the minor child referenced above, hereby authorize and request that you release all records concerning findings and treatment of \_\_\_\_\_ that you have in your possession to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand and agree that only **copies** of those records and radiographs contained in Pima Pediatric Dentistry files will be released and that the originals will remain the property of Pima Pediatric Dentistry. I hereby release Pima Pediatric Dentistry (Marc A. Auerbach, D.D.S.) from any liability related to disclosure of confidential or privileged information. Unless revoked sooner, this authorization will expire one year from the date found below.

\_\_\_\_\_  
(Signature of parent or authorized individual)

\_\_\_\_\_  
(Printed name of parent or authorized individual)

\_\_\_\_\_  
(address)

Date: \_\_\_\_\_

Witness: \_\_\_\_\_