

**AUTHORIZATION TO RELEASE
PATIENT RECORDS
TO
PIMA PEDIATRIC DENTISTRY**

To: _____ (name of previous dentist)

Address: _____

Phone: _____

Concerning: _____ [name of patient]

D.O.B.: _____ Male Female

As the parent or legal guardian of _____, I hereby authorize and request that you release legible copies of all records concerning findings and treatment of him/her that you have in your possession to:

PIMA PEDIATRIC DENTISTRY
MARC A. AUERBACH, D.D.S.
8567 NORTH SILVERBELL ROAD, SUITE 101
TUCSON, ARIZONA 85743
520-744-2663

I hereby release the above referenced dentist from any liability related to disclosure of confidential or privileged information. I understand and agree that only copies of those records and radiographs contained your files will be released and that the originals will remain the property of the dentist. Unless revoked sooner in writing, this authorization will expire one year from the date found below.

Dated: _____

(Signature of parent or authorized individual)

(Printed name of parent or authorized individual)

(address)

Witness: _____

According to A.R.S. §32-1264 on a patient's request the dentist, dental hygienist or denturist shall, within 15 days, transfer quality copies of the patient's records to another licensee or certificate holder or the patient may receive a copy. The patient may be charged for the reasonable costs of copying and forwarding the records. "Records" is further defined to include all treatment notes, prescriptions, diagnosis and treatment planning, dental charting and radiographs.