Sophie L. Baird, D.D.S., M.S.D. ~ Board Certified Pediatric Dentist

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 of 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
8567 NORTH SILVERBELL ROAD, SUITE 101
TUCSON, AZ 85743

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 release 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.

_____ Date:_____
(Signature of parent or authorized individual)

_____ Witness: _____
(Printed name of parent or authorized individual)

_____
(Address)

According to A.R.S 32-1264 on 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 all treatment notes, prescriptions, diagnosis and treatment planning, dental charting and radiographs.