CONSENT FOR RELEASE OF PATIENT RECORD INFORMATION FROM SCRIPPS PEDIATRIC DENTISTRY

Please fill the Form COMPLETELY & email to staff@scrippspediatricdentistry.com

Name of Patient: ____

Parent/ Legal Guardian: ______________________________________

Address of Patient: ____
Number & Street Apt.

____
City State Zip

Patient Date of Birth:___/____/____

I hear by authorize Scripps Pediatric Dentistry the right to release the most recent patient's Radiographic Images to :

Dental Office Name: ____

Phone: ___________________ e-Mail Address: _______________________

I understand I may revoke this consent at any time except to the extent that action has already been taken on it and that it will expire automatically ninety (90) days from the date below. There is 2 working days required to process the request and a fully COMPLETED form is required.

Dr. S. J. Shahangian and associates, by releasing authorized information, is hereby relieved from all legal responsibility or liability for the release of the information described above to the extent indicated and authorized herein.

I acknowledge that I was given the choice of hard copy picked up from the office but I chose the email rout and I understand that e-Mail communication may NOT be perfectly safe and there is a small possibility of the email been intercepted by others.

______________________________ ____________________
Parent or Legal Guardian Signature Date

P: (858) MY-FLOSS
P: (858) 693-5677
Email: Staff@ScrippsPediatricDentistry.com
www.ScrippsPediatricDentistry.com
9840 Hibert Street, Suite B-4, San Diego, California 92131

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