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**Authorization for Release of Medical Records**

In order to protect patient confidentiality, Piedmont Regional Dental Clinic (PRDC) asks you to review the following before signing.

I, (print name) \_\_\_\_\_ authorize PRDC staff to release medical or dental records on my behalf to the following entity/provider:

Physician / Provider's Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Email Address: \_\_\_\_\_

\_\_\_\_\_ Please release a full copy of my dental/or medical records

\_\_\_\_\_ Please release only the specific information requested

\_\_\_\_\_ Please release only the following information

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

I understand that by signing below I am allowing my medical/dental records to be transferred from one office to another and that there is a chance that they may accidentally be released to someone other than those entities listed above. I understand that Piedmont Regional Dental Clinic may release my records/information by fax, email, or mail. I further acknowledge that this release is valid for one year unless otherwise noted below.

\_\_\_\_\_ This is a one-time release of information

\_\_\_\_\_ This release is valid until the following date: \_\_\_/\_\_\_/\_\_\_ (no more than one year from the date signed)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient Name (printed) Patient Date of Birth

\_\_\_\_\_  
Signature of Patient or Decision Maker if Minor or Unable to sign

\_\_\_\_\_  
Decision Maker (print name) if Signing for Patient Reason Signing for Patient