PIEDMONT
REGIONAL DENTAL CLINIC
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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 medical or dental records to be released from the following entity/provider on my behalf:

Name: _____
Address: _____City: _____State: _____ Zip: _____
Phone Number: _____ Fax Number: _____

_____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 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 request my records be sent by fax, mail or e-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