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Lodi, CA 95240
Tel: 209-400-2018

1660 W. Yosemite Ave. #1
Manteca, CA 95337
Tel: 209-500-1910

3633 Bradshaw Rd. #A
Sacramento, CA 95827
Tel: 916-810-2025

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

I hereby authorize, Bethel Kids Dental to release the information in the dental record of _____ (Patient's name and Date of Birth) to

(name of dentist, physician, clinic, or patient's representative)

(address)

Any and all information may be released including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below.

This authorization is effective now and will remain in effect until _____ (date). I understand that I may receive a copy of this authorization.

Signature

Print Name

Date

If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

NOTE: This authorization is intended to comply with applicable state laws. It is not intended as a "Consent" or "Authorization" for the use and disclosure of Protected Health Information (PHI) under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or its implementing regulations. The medical/dental provider to whom this authorization is directed should ensure that he or she is in compliance with applicable HIPAA requirements before releasing the requested records.

