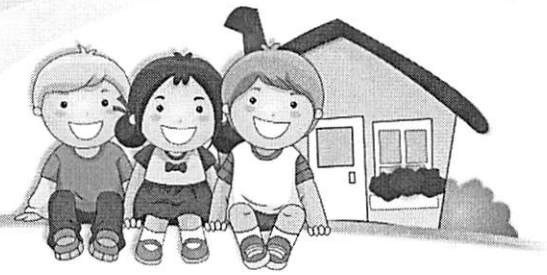
The Children's Dental Cottage
Pediatric Dentistry
Specializing in Infants, Children, Teens, and Individuals with Special Needs



Authorization to Release PHI (Protected Health Information)

Patients Name: _____ **Date of Birth:** _____

Please send records and Information to the address below:

Name: _____

Address: _____

City/State: _____ Zip Code: _____

E-Mail: _____

Phone #: _____ Fax #: _____

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

_____ _____

Signature of Parent /Guardian (or Patient if over 18 years old) Date

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