Dentistry for Kids
Amy Waxman, DMD & Lisa Honig, DDS
Pediatric Dentistry & Orthodontics for Infants, Children, & Teenagers

Authorization to Release Dental Records and Radiographs

HIPAA Authorization for Disclosure of Protected Health Information

1. PATIENT

Patient's name: _____ Date of birth: _____

2. PERSON SIGNING (IF NOT THE PATIENT)

Parent/guardian name: _____ Relationship: _____

3. RELEASE RECORDS TO

I authorize Dentistry for Kids (Amy Waxman, DMD PA) to disclose the dental records and radiographs (x-rays) of the patient named above to:

Name of person or dental office: _____

Email address: _____

4. PURPOSE OF RELEASE

☐ Transfer of care / referral to another provider ☐ At my request (personal use)

☐ Insurance or payment ☐ Other _____

5. EXPIRATION

This authorization expires one year from the date signed, or on the date below if earlier, or upon completion of the transfer of care.

Earlier expiration date (optional): _____

6. IMPORTANT INFORMATION

Right to revoke. I may revoke this authorization at any time by giving written notice to Dentistry for Kids. Revocation will not affect information already disclosed in reliance on this authorization.

No conditions. Dentistry for Kids will not condition my (or my child's) treatment, payment, or enrollment on whether I sign this authorization.

Redisclosure. Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy law.

Copy. I am entitled to a copy of this signed authorization.

I am the patient, or the parent/legal guardian with the authority to make health care decisions for the patient named above.

Signature: _____ Date: _____

Printed name (and relationship to patient, if not the patient): _____