Tots N' Teens Pediatric Dental Specialist

League City: 2950 Gulf Fwy S, Ste A, League City, TX 77573 | Ph (281) 337-3222 | Fax (281) 337-9222
Deer Park: 3317 Center St, Deer Park, TX 77536 | Ph (281) 377-3332 | Fax (281) 377-4741
www.tntdentistry.com | info@tntdentistry.com

Authorization to Release Dental / Health Information

PATIENT

Patient's name | Previous name (if any) | Date of birth | Phone

Address | City / State / Zip

REQUEST

Please check one: ☐ Send records FROM another provider TO Tots N' Teens

☐ Send records FROM Tots N' Teens TO another provider

☐ Give a copy of my child's records to me (parent/guardian)

Tots N' Teens office: ☐ League City ☐ Deer Park

Other provider / recipient

Provider or office name | Specialty | Phone

Address | City / State / Zip | Fax

INFORMATION TO BE RELEASED

☐ All dental records ☐ X-rays / images ☐ Treatment notes ☐ Medical / health history ☐ Billing / insurance records ☐ Orthodontic records

Other / specific dates of service

Purpose: ☐ Continuing care ☐ Personal use ☐ Insurance ☐ Legal ☐ Other

EXPIRATION

This authorization expires 180 days from the date signed, unless a different date or event is written here:

Expiration date or event (optional)

PLEASE READ

- I understand that health information released under this authorization may include information about diagnosis and treatment, and, if part of the record, information about communicable disease, HIV/AIDS, mental health, or drug or alcohol use.
- I may revoke this authorization at any time by giving written notice to Tots N' Teens Pediatric Dental Specialist, except to the extent that action has already been taken in reliance on it. Our Notice of Privacy Practices explains how to revoke.
- Tots N' Teens Pediatric Dental Specialist will not condition my child's treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
- Information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy law.
- I am entitled to a copy of this signed authorization.

Signature of patient or parent/legal guardian | Date | Relationship / authority to act for patient

Printed name of person signing | Office use: received by | Date sent