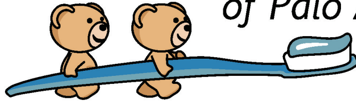
Pediatric Dentistry
of Palo Alto



Compassionate care for children, adolescents & those with special needs

Vernon J. Adams Jr., DMD & Jonathan M. Hurng, DDS, MPH

Authorization for Release of Medical Information & Authorization for Use/Disclosure of Protected Health Information

I hereby authorize **Pediatric Dentistry of Palo Alto**

325 Sharon Park Dr. Ste. D3 Menlo Park, CA 94025 (650) 321-6448

To disclose to: ____ (Printed name of recipient)

____

Address

____

City, State, Zip, Telephone & ***Forwarding Email Required***

Name of Patient: ____ Date of Birth: ______________

Check the box and Initial to specify which type of information is to be disclosed:

- ○ Dental Records
- ○ X-Ray Results
- ○ Other ___________________________________

Revocation: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be in effort upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Re-Disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Authorization Representative of Patient:

____

Signature

____

Name (Printed)

____

Relationship to Patient

____