METROPOLITAN PEDIATRIC DENTAL ASSOCIATES | RELEASE OF RECORDS

STEP 1: ENTER PATIENT INFORMATION:

Patient Name (Last, First, and MI):	**Date of Birth (MM/DD/YYYY):**
Phone:	**Account #:**

STEP 2: SELECT DESIRED SERVICE:

☐ Dental Records Only ☐Dental X-Rays Only ☐Dental Records & X-Rays

STEP 3: ENTER WHERE YOU WOULD LIKE THE INFORMATION SENT: (Please select only one)

☐ **SEND BY MAIL TO:** (5-7 business days)

Name: _____

Address: _____

Ste/Apt #: _____

City/State: _____

Zip Code: _____ Phone: _____

☐ **SEND BY EMAIL TO:** (2-3 business days)

Name: _____

E-mail: _____

☐ **PICK UP** (5-7 business days)
*You will receive a confirmation phone call when your records are ready to be picked up.

STEP 4: REASON FOR REQUEST: _____

STEP 5: SIGN BELOW: (PATIENT OR LEGAL REPRESENTATIVE SIGNATURE)

I understand the following:

1. The information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics.
2. The information authorized for release may include records that may indicate the presence of a communicable or non-communicable disease.
3. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. This authorization may be revoked by providing written notice to: Metropolitan Pediatric Dental Associates, 1021 Bandana Blvd E, Ste 121, St. Paul, MN 55108.
4. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.
5. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
6. This authorization will expire 1 year from the date signed below.

By signing below, you agree that you understand and accept the terms on this form. You give Metropolitan Pediatric Dental Associates permission to have your records copied, picked up, mailed, or electronically sent to the indicated party above.

Signature: _____ Date:_____

STEP 6: SUBMIT THE SIGNED RELEASE FORM by dropping off, mailing, or emailing to one of our 4 Twin Cities locations. Contact info can be found on our website at **METROPEDIATRICDENTAL.COM.**