Brittany Adamiak, DDS
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Authorization to Release Records to GHPD

Patient (s) Name: _____

Patient Date Of Birth: _____

Parent Name: _____

I hereby authorize and request the following provider (name of

office/doctor)_____ to disclose my child's dental records and give copies to **Green Hills Pediatric Dentistry.**

Please release any and all records and information which you may have in your possession, including but not limited to the following; dental records including operative records, diagnosis, dental history, findings and procedures, treatment notes, radiographs, diagnostic models and additional materials.

In consideration of such disclosure on the part of the above named parties, I hereby release them from any and all liability arising from such disclosure.

Parent Signature _____ Date _____