



* 1 7 0 0 5 3 *

Name _____

BCH MRN#: _____

DOB: _____

Gender: _____

Authorization For Release of Medical Records (Dental Only)

To request release of medical information please complete and sign this form and return it to:

Department of Dentistry HU-4
Children's Hospital Boston
300 Longwood Avenue
Boston MA 02115

You may submit this form via fax 617-730-0478 or email dentistry@childrens.harvard.edu
If you need help completing this form please contact the Department of Dentistry at
617-355-6571.

Please allow 7-10 business days to complete this request. Please print legibly.

Patient Information		
Patient Last Name _____	First Name _____	MI _____
Street Address _____		Apt# _____
City _____	State _____	Zip _____
Children's MR# _____	Home Telephone () _____	
Date of Birth _____	Alternate Telephone () _____	
Children's Hospital has my permission to release information contained in the Medical Record of the above named patient.		
Information Requested (please be specific and enter date of service if known): Email address required to send radiographs.		
Restrictions and/or Exclusions (if any):		
Purpose of Release:		
Children's Hospital will provide the information requested above to the following party:		
Name _____		
Attention of _____	Telephone _____	
Email _____	Fax _____	
Street Address _____	Suite/Room _____	
City _____	State _____	Zip _____

I hereby authorize Children's Hospital Boston (Children's) to release any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded, except psychotherapy notes. I am aware that Children's cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Children's may or may not protect this information once it has been disclosed to the recipient.

Information will not be released without a valid signature below. This authorization will expire 90 days from the signature date. I can however, cancel this authorization in writing at any time, except to the extent that Children's has relied upon it. For example, if I cancel it after Children's has sent requested records, Children's will not retrieve those records. Instructions for canceling this authorization are included in the Children's Notice of Privacy Practices. I understand that Children's will continue to provide care, even if I do not authorize this release.

<i>Patient signature is required for patients who are 18 years or older, or who have emancipated minor status, or a special condition as defined by law. Parent or legal guardian signature is required for patients under age 18 without emancipated status or a special condition.</i>		
_____ Signature of Patient	_____ Date	
_____ Signature of Parent or Guardian	_____ Relationship to Patient	_____ Date

Please make a copy of this release for your records.