

Chapel Hill Pediatric Dentistry  
205 Sage Rd, Ste. 202  
Chapel Hill, NC 27516  
Tel. (919) 929-0489 Fax (919) 933-3631

## Release of Patient Record Information

Name of Patient: \_\_\_\_\_

Address of Patient: \_\_\_\_\_

Phone# \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby authorize Dr. Avni Rampersaud and/or Associates of Chapel Hill Pediatric Dentistry to release information to:

\_\_\_\_\_  
\_\_\_\_\_

\* Please include name, address, phone number and email address of the hospital, dentist or individual to RECEIVE information\*

the following information: ALL DENTAL RECORDS covering the period of care from the last 3 years.

I understand I may revoke the consent at any time except to the extent that action has already been taken on it and that it will expire automatically ninety (90) days from the date below.

I Dr. Rampersaud, by releasing authorized information, are hereby relieved from all legal responsibility or liability for the release of the information described above to the extent indicated and authorized herein.

\_\_\_\_/\_\_\_\_/\_\_\_\_

Date

\_\_\_\_\_

(signature of the parent or Guardian)