205 Sage Rd, Ste. 202
Chapel Hill, NC 27514
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*

ALL DENTAL RECORDS covering the period of care from the last 3 years will be released.

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)