Brent D. Johnson, DDS, MS

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Authorization for Release of Medical Record Information

To request release of medical information from Pediatric Dentistry, P.C. to another office or individual, please complete and sign this form and return it to:

Pediatric Dentistry, P.C.
3901 Pine Lake Road, Suite 250
Lincoln, NE 68516

or you may submit this form to Pediatric Dentistry, P.C. by fax to: (402) 423-3329

Patient Name (Last, First, MI) ______________________________

Patient Address ______________________________

City ____________________ State __________ Zip __________

Patient Home Telephone (   )____________________

Patient Date of Birth ______________ Social Security # ____________________

Purpose of Release:

Please send Medical Record Information to:

Name ______________________________

Address ______________________________

City ____________________ State __________ Zip __________

Phone (   )______________ Email ____________________

I hereby authorize Pediatric Dentistry, P.C. to release the medical information as requested above. I am aware that Pediatric Dentistry, P.C. cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Pediatric Dentistry, P.C. may not protect this information once it has been disclosed to the recipient. I understand that Pediatric Dentistry, P.C. may charge a small fee, in accordance with Nebraska Statute 71-8404, to provide a copy of the medical information.
Information will not be released without a valid signature below. This authorization will expire 180 days from the signature date. I can however, cancel this authorization in writing at any time. I understand that Pediatric Dentistry, P.C. will continue to provide care, even if I do not authorize this release.

Patient signature is required for patients who are 19 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 19 without emancipated status of a special condition.

______________________________	______________	______________
Signature of Parent or Guardian	Relationship to Patient	Date
______________________________	______________	
Signature of Patient	Date	

Please make a copy of this release for your records.