

# NAPLES PEDIATRIC DENTISTRY

## Consent For Release Of Medical Records **And** Disclosure Of Protected Health Information

I, \_\_\_\_\_ (parent or guardian), hereby authorize **Naples Pediatric Dentistry** (Marilyn C. Sandor, D.D.S., M.S., P.A.) to disclose medical information contained in my child's pediatric dental record in accordance with the Notice of Privacy Practices. I have been given the opportunity to review the Notice of Privacy Practices, to ask questions about it, and do hereby agree to its terms. A copy of this signed, dated consent shall be as effective as the original. I release, hold harmless, and agree to indemnify **Naples Pediatric Dentistry** (Marilyn C. Sandor, D.D.S., M.S., P.A.), and its employees and agents for any and all liability. This includes, but is not limited to, negligence arising from or occurring as a result of this consent. I specifically authorize **Naples Pediatric Dentistry** (Marilyn C. Sandor, D.D.S., M.S., P.A.) to disclose verbally, by mail, fax, or unencrypted e-mail the contents of my child's medical records.

### **Complete as Applicable:**

1. Please send a copy of my child's records (including information from other health-care providers that it may contain) to \_\_\_\_\_ at \_\_\_\_\_.

I understand that my child's records may be subject to re-disclosure by recipient(s) and unprotected by federal and state law.

2. Please allow \_\_\_\_\_ to pick up a copy of my child's records (including information from other healthcare providers that it may contain). Records will be available within 48 hours of receipt of this request.

3. I acknowledge I will be assessed a charge for duplication of records as allowed for by Florida law.

**Name:** \_\_\_\_\_ (Please Print)

**Date:** \_\_\_\_\_  
(Parent or Guardian)

**Signature:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_