Boston Children's Hospital
Until every child is well™

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Use Plate, Label, or Print:

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.

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.

_____ _____
Signature of Patient **Date**

_____ _____ _____
Signature of Parent or Guardian **Relationship to Patient** **Date**

Please make a copy of this release for your records.