Heidi J. Stark
Diplomate, American Board of Pediatric Dentistry
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Diplomate, American Board of Pediatric Dentistry
Emily J. Egley
Diplomate, American Board of Pediatric Dentistry
Katie J. Garcia
Diplomate, American Board of Pediatric Dentistry

Release to Consult and Release of Records

Parent or Guardian Name: ____

Patient's Name and Date of Birth: ____

Relationship to Patient: ____

As a patient or guardian of the patient of Lincoln Pediatric Dentistry, I give my consent to allow the said dental office to use and disclose my protected dental health information to carry out consultation, treatment and payment activities. I have the right to revoke this consent at any time by submitting written notice. I give my permission to allow said dental office to consult with or transfer records to/from:

Name: ________________________________ Phone Number: ____

Address: ____

Email Address: ____

Reason for Release of Records: ◻ Moved ◻ Out of Network insurance ◻ Graduate to General Dentist
Other:____

◻ I request most current x-rays to be emailed to the above email address at *no charge.*
◻ I request <u>copies</u> of most current x-rays to be sent to the above named entity. Enclosed is payment in the amount of $10.00 (per patient) to cover the cost.
◻ I do not wish to have x-rays sent.

____ Date: ____________________
Signature of patient, parent or guardian

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