LINCOLN 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 copies 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

North Office 3272 Salt Creek Cir. Lincoln, NE 68504 | **Southeast Office** 4301 S. 80th St. Lincoln, NE 68516

East Office 7001 A St., #103 Lincoln, NE 68510 | **Yankee Hill Office** 3811 Grainger Pkwy Lincoln, NE 68516

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