Consent for Release of Dental Records and Disclosure of Protected Health Information

I, _____ hereby request and authorize
Patient, Parent or Guardian's Name

Levitt & Prasatthong, D.D.S., P.A. to disclose and provide copies
Practice or Dentist Name
of any and all clinical treatment records and information concerning my child's care—or my care as I am over 18 years of age—which is in the possession of this person or entity, to :

_____
Name of parent, new dentist, specialist, consultant, patient, attorney, insurer, etc.

_____
Address

_____
City State Zip Telephone Number

****E-mail address:** _____

These records include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment plans, treatment records, referral and consultation recommendations and reports, diagnostic models, and other related materials.

I expressly release from liability the above named person or entity from any and all liability arising from compliance with this request and disclosure of the requested information for the following patients

_____ _____
Name and D.O.B Name and D.O.B

_____ _____
Name and D.O.B Name and D.O.B

_____ _____
Signature of Patient or Guardian Date

LEVITT & PRASATTHONG, D.D.S., P.A.
7701 38th Ave. No., St. Petersburg, FL 33710
kidsdoc@toothfun.com
Phone #: (727) 345-3151
Fax #: (727) 345-6551