Community Dental Center
We Care for Kids

259 Hydraulic Ridge Rd., Suite 101, Charlottesville, VA 22901
(phone) 434-293-9300 (Fax) 434-973-9310 www.cdcva.org

Dental Records Release Form

For the patient(s) identified in the list below, I, _____ authorize Community Dental Center to release all medical records to the following agency and/or office:

Office Name _____

Address _____

Phone number_____

Patient Name	Date of Birth	Social Security Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that this may or may not include x-rays and that I am responsible for their retrieval.

- I understand that these records may contain information from other health care providers, as well as information which may be administrative in nature.
- I understand that these records may be used and disclosed to carry out treatment, payment, or health care operations.
- I understand that I may review this practice's Right of Notice for further uses and disclosures prior to signing this consent.
- I understand that I have the right to restrict how my information is used or disclosed and that this practice has the right to disagree with the requested restriction.
- I understand that this practice has no responsibility for the use or distribution of this information by the party to whom it is released. I release you from all liability which may arise from your compliance with this request to medical records.
- I further understand this consent is valid for a period of one (1) year from the date signed below. If you wish to revoke this consent, written notification is required. A period of two business days, from the date revocation arrives in the office, is needed to put this request in place. I understand any records sent prior to revocation received will remain with said entity.

- **I authorize you to transmit this information by facsimile transmission (fax) and/or email, and release you from any liability for breach of confidentiality, misdirection of transmission or failure to receive transmission if my records are transmitted by fax and/or email.**

_____ _____

- **Patient/Legal representative signature** **Date**