



Aloha Pediatric Dentistry Release of Records

Patient(s) Name: _____

Patient(s) DOB: _____

I hereby request and authorize the release of dental records, including radiographs, and/or other available charting information to the following named Dental Practice/Doctor:

Practice/Doctor: _____

Mailing Address: _____

Email address: _____

Signature (Of Parent if Patient is a minor)

Date

South Berkeley Office
2640 Telegraph Ave #101
Berkeley, CA 94705
(510)848-6494
FAX (510)848-9329

North Berkeley Office
906 Ensenada
Berkeley, CA 94707
(510)528-1546
FAX (510)528-4362

Orinda Office
3 Altarinda Rd.#210
Orinda, CA 94563
(925)253-8190
FAX (925) 253-8199

The PHI (Personal Health Information) contained in this fax/letter is HIGHLY CONFIDENTIAL. IT is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare service to this patient. Any other use is a violation of Federal Law (HIPPA) and will be reported as such