



# 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

To help us improve patient care, we'd love to know why you decided to no longer see us: \_\_\_\_\_

\_\_\_\_\_

*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.