Kanawha City
pediatricdentistry
Don E. Skaff DDS, Inc.
Making Happy Smiles

CONSENT TO RELEASE INFORMATION

Provided at Kanawha City Pediatric Dentistry

Patient Name:_____DOB:_____

I hereby give consent to release (list specific information being requested):

_____ on above patient provided at Kanawha City Pediatric Dentistry to the below named office/individual (Name and address/email of person to receive information):

_____

_____

_____

_____

Parent/Guardian requesting information Relationship to Patient

_____

Signature Date

Please see our HIPAA Privacy and Security Policies and Procedures for information regarding your rights to revoke this authorization. This request must be completed within 30 calendar days per state requirement. You may put an expiration date for this consent:_____

Diplomate, American Board of Pediatric Dentistry

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