Middle Tennessee Pediatric Dentistry
Authorization to Release Dental Information

Return the form to our office or fax it to (615) 827-0202. Requests will usually be processed within 5 days.

The execution of this form does not authorize the release of information other than that specifically described below.

I request and authorize Middle Tennessee Pediatric Dentistry to release the information below regarding (patient name)_____, date of birth: _____, to the below listed organization, agency, or individual:

Parent or Dental/Medical Office Name:
_____
Address: _____
Phone Number: _____
Fax Number: _____

Information Requested:
__Copy of dental charting
__Copy of dental radiographs
__Other (describe) _____

Purpose for which information is to be used:
__Transfer of records
__Second opinion
__Other (describe) _____

I understand that the dental records maintained by Dr. Bryan Byrnside may contain dental and administrative information from other healthcare providers. I also understand that the practice of Dr. Byrnside may charge a copy fee for the duplication of x-rays and records.
This authorization shall remain in effect until revoked by me in writing. All prior authorizations, if any, are hereby cancelled.

Signature: _____
Date: _____