West Metro Pediatric Dentistry Request and Authorization for Records Release

Please note:

- Records can only be requested by a legal guardian.
- Records releases may take up to 30 business days from receipt to complete.
- However, we will make every attempt to complete records releases with 5 business days.
- Please email the request to info@westmetrokidsdental.com.
- Records (patient x-rays and records summary) will be emailed to the legal guardian's email address provided below.

Child's Name:	DOB:	
Child's Name:	DOB:	
Child's Name:	DOB:	
Child's Name:	DOB:	

I hereby authorize the use and disclosure of patient information for the above listed children, of whom I am legal guardian. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the							
recipient and may no longer be protected by HIPAA Privacy regulations.							
Legal Guardian (print):						DOB:	
Please note, by providing an email address for the records to be sent to, you are acknowledging that you are aware of							
the risk of sending health information via unsecured/unencrypted e-mail. Due to the vulnerabilities of email, third parties							
may be able to access health information within this email. West Metro Pediatric Dentistry is not liable for health							
information sent via email at your request.							
Legal Guardian email address to							
receive records at:							
I understand that I may revoke this authorization at any time, except to the extent that action has already been taken,							
and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at							
15530 W. 64th Avenue, Suite H, Arvada, CO 80007. Without my express revocation, this consent will automatically							
expire upon satisfaction of the request and/or after 180 days.							
Legal Guardian Sig	nature:					Date:	

I am requesting my child's records because:				
We are moving out of state.				
We are moving to a new area of the city.				
My child is graduating to an adult dentist.				
We are unable to complete treatment here (list reason).				
I would like a second opinion (list reason).				
Other (list reason):				

For Office use Only				
Request Received On:				
Request Completed On:				
Request Completed By:				