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Record Release / Transfer Out

I, the undersigned, give my permission for Five Cities Pediatric Dental Group to release protected health information for my child(ren): _____ to the following dental practice: _____.

I request for an electronic copy of the information to be sent to the following e-mail address:

_____. I recognize that e-mail may not be a secure form of communication. There is some risk that individual health and/or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties.

Parent /Guardian Signature: _____ Date: _____

Parent/Guardian name (printed): _____