Salida Surgery Center
Dental Group
5712 Pirrone Road
Salida, CA 95368
Phone (209) 543-9299 Fax (209) 543-9699

Medical Records/ Release of Information/ Authorization to Request Records

Patient Name: _____ D.O.B: _____

Address: _____ City: _____ State: _____ Zip: _____

Parent/ Legal Guardian's Name: _____

I, _____, hereby authorize Salida Surgery Center, to obtain all medical / dental information / records in order to aid and facilitate my child's pre-operative clearance. This information is required for medical evaluation for determining patient medical condition and feasibility for surgery and general anesthesia. I understand I have the right to refuse signing this form. I also understand by not signing, it may have negative consequences and services may not be provided.

My child will be undergoing general anesthesia for dental surgery and the disclosure of information authorized herein is required for that purpose only.

This release of information expires one year from date of signature. I have the right to revoke this authorization in writing at any time.

Records to be released:

X_____ _____ _____
Parent/ Legal Guardian Signature Date Time am/pm