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Authorization to Release Dental Records

PATIENT INFORMATION:

 Full Name

 Street Address

 City, State, Zip Code

____/____/____ _____
 Date of Birth Phone

SEND RECORDS TO:

 Self or Name of Dentist, Physician, Agency, Etc.

 Street Address

 City, State, Zip Code

____-____-____ _____
 Phone Fax

Send via e-mail: _____

INFORMATION TO BE DISCLOSED:

- Exam & Treatment Notes Date: _____
- Radiographs (X-rays) Date: _____
- Treatment Plan Date: _____
- Other (specify): _____

PURPOSE(S) FOR DISCLOSING INFORMATION:

- Continuation of Care/Consultation
- Attorney Inquiry/Legal Matter
- Insurance Claim/Application
- Other (specify): _____

I understand that all information I hereby authorize to be obtained will be held strictly confidential and cannot be released without my written consent. I understand that this authorization will remain in effect until revoked by me in writing.

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time by submitting my request in writing.

Print Name (Patient/Guardian): _____

Signature (Patient/Guardian): _____

Date: _____

Signature of Witness: _____

Date: _____

AUTHORIZATIONS SIGNED BY A LEGAL REPRESENTATIVE MUST INCLUDE A COPY OF THE GUARDIANSHIP PAPERS OR A POWER OF ATTORNEY.