ConfiDental
Smile with Confidence!

Authorization for Release of Medical Record Information

To request release of medical information, please complete and sign this form and return to our dental office.

Patient Infomration

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell Phone: _____

Information Requested

Please be specific and enter date of service if known:

_____

_____

_____

ConfiDental PC will provide the information requested above to the following party:

Name/Practice: _____ Attention: _____

Address: _____ Suite: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email: _____

Purpose of Release: _____

_____

Restriction and/or Exclusions (if any**)** : _____

_____

I hereby authorize ConfiDental PC to release any medical information as requested above. This information will include any dental conditions, recommended or performed treatment, as well as x-rays. I am aware that ConfiDental PC cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Confidental PC may or may not protect his information once it has been disclosed to the recipient.

Information will not be released without a valid signature below; this authorization will expire 90 days from the signature date. I can however, cancel this authorization in writing at any time, except to the extent that ConfiDental PC has relied upon it. For example, if I cancel if after ConfiDental PC has sent requested records; ConfiDental PC will not retrieve those records. Instructions for cancelling this authorization are cinldued in the ConfiDental PC's Notice of Privacy Practices. I understand that ConfiDental PC will continue to provide care, even if I do not authorize this release.

Patient signature is required for patients who are 18 years and older, or who have emancipated minor status, or a special condition defined by law. Parent or legal guardian signature is required for patients under the age of 18 without emancipated status or a special condition.

_____ _____ _____

Signature of Patient / Parent or Guardian **Relation to Patient** **Date**

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