Authorization to Release Dental Records

Patient Information:

____
Full Name

____
Street Address

____
City, State, Zip Code

( ) - ____/____/____

Phone Number **Date of Birth (mm/dd/yy)**

Send Records to:

____
Practice Name

____
Address

____
City, State, Zip Code

( ) - ( ) -

Phone Number **Fax Number**

☐ Send via email:

____

Information to be disclosed:

☐ Exam & Treatment Notes Date: ___/___/___

☐ Radiographs (X-rays) Date: ___/___/___

☐ Treatment Plan Date: ___/___/___

☐ Other (specify) ______________________________

I understand that all information I hereby authorize to be obtained with 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 content at any time by submitting my request in writing.

____
Print Name (Patient or Guardian)

______________________________ ______________________________
Signature (Patient or Guardian) Date

______________________________ ______________________________
Witness Signature Date

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