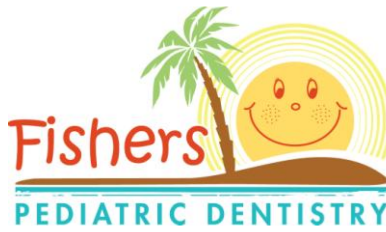

Authorization to Release Dental Records

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:

- ☐ Consultation
- ☐ Continuation of Care
  - Archive Patient of Record ☐Yes ☐No
- ☐ Attorney Inquiry/Legal Matter
- ☐ 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.

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