growing smiles
WHERE HEALTHY SMILES BEGIN

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
- ☐ Attorney Inquiry/Legal Matter
- ☐ Other (specify): ____________________________

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

I understand unless otherwise limited by state or federal regulations, and except to the extent 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. These can be attached here or faxed to (219) 286-6149.