AUTHORIZATION TO RELEASE DENTAL INFORMATION

(The execution of this form does not authorize the release of information other than that specifically described below)

TO:_____ RELEASE TO:_____

_____ _____

_____ _____

Patient Name:_____ DOB:_____ SSN: _____

I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes the following information:

INFORMATION REQUESTED:

___ Copy of complete dental chart

___ Copy of dental x-rays

___ Other (e.g. models· describe)

_____

DATES COVERED:

___ All treatment rendered in this office or by this doctor

___ Limited to treatment dates for conditions described below:

_____

_____

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

___ Transfer of records ___ Second Opinion

___ Other _____

AUTHORIZATION*: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event: on_____ (date supplied by patient); or____ if revoked in writing by patient; or ___ 180 days from the date hereof; or ___ under the following conditions: _____*

_____

OTHER CONDITIONS: A copy of this Authorization or my signature thereon: _x_ may, ___ may not be used with the same effectiveness as an original.

_____
PATIENT NAME (print)

PERSON AUTHORIZED TO SIGN FOR PATIENT:

_____ _____
PATIENT SIGNATURE

DATE _____ State How Authorized_____