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AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

Patient Name:_____ Date of Birth:_____
Previous Name:(if applicable)_____
Release to Doctor:_____
Address:_____
Phone_____ Email:_____

I request and authorize the above-name doctor or health care provider to elease the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):
Information requested:
____ Copy of complete dental chart
____Copy of dental x rays
____ All treatment rendered
____ others (E.G Models-describe)

Purpose or need for which information is to be used:

_____ Transfer of records _____ Second Opinion

_____ Other, Please explain_____

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the nest 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. With my express revocation, this consent will automatically expire upon satisfaction of the need for the disclosure, but in and event: date supplied by patient; or if revoked in writing by patient; or 180 days from the date hereof; or under the following conditions:_____.

_____
Patient Name (print) Date

_____
Signature

Office Use ONLY

_____
Date Received

_____
Date Sent

_____
Signature Authority