Miller Dental
302 2nd Avenue SW
Jamestown ND 58401

Phone: (701) 252-1661
Fax: (701) 252-1228
Email: infomiller@gondtc.com

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: _____ DOB: _____ SSN: _____

Current Dentist: _____ Release To: _____

Fax: _____ Email: _____

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 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)

DATES COVERED:
*Limited to treatment dates and for condition described below:

_____

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 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. With 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 ___ may or ___ may not be used with the same effectiveness as an original.

_____
Patient Name (Print)

_____ _____
Person authorized to sign for patient State how authorized

_____ _____
Signature Date