Joseph Salas DMD

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Requesting From:

Patient Names:

Patient DOB:

Patient 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 information regarding the following condition(s):

**INFORMATION REQUESTED:**

\_\_\_\_ Copy of Dental Radiographs (FMX and BWX with date of service)

\_\_\_\_ Copy of Complete Dental Charting

\_\_\_\_ Other Comments: Date of last Cleaning, if Perio Maint please provide charting, FMX, BWX, Periodic

**PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:**

\_\_\_\_ Transfer of Records \_\_\_\_Second Opinion\_\_\_\_Other Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 expressed revocation, this consent will automatically expire upon satisfaction of the need for disclosure.

**OTHER CONDITIONS:** A COPY of this Authorization or my signature thereon \_\_\_\_ may, or \_\_\_\_ may not be used with the same effectiveness as an original.

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Patient Name (Print) Patient Name (Print)

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Patient Signature Date Patient Signature Date