Bruce Hoggan, DDS
225 Callahan Ave.
Parachute, CO 81635
Phone: 970-285-7748
Fax: 970-285-6824

AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

Previous Dentist(s) info to request records:

_____

_____

_____

PHONE: _____
FAX: _____
EMAIL: _____

Patient Name: _____

Date of Birth: _____

Date Signed: _____

RELEASE RECORDS TO:
H~DENTISTRY
225 CALLAHAN AVE
PARACHUTE, CO 81635
om.hdentistry@gmail.com

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.

INFORMATION REQUESTED:

_____ Copy of complete dental record (including periodontal charting)

_____ Copy of dental x-rays (BW within 1 year, FMX, Pano within 5 years)

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 event that the 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.

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 Signature

_____
Signature of Personal Representative

_____
Person authorized to sign for Patient (Print please)

_____
Relationship to Patient if Personal Representative