AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

To (Current Dentist): _____

Address: _____

_____

Phone: _____ 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 in this request.

Release To: _____

Address: _____

_____

Phone: _____ Fax: _____

Email: _____

Patient: _____

Date of Birth: _____

SSN: _____

Information requested:

_____ Copy of Complete Dental Chart
_____ Copy of Dental Radiographs
_____ Other (models, etc.) Describe: _____

Purpose or need for which information is to be used:

_____ Transfer of Records
_____ Second Opinion
_____ Other Describe: _____

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.

_____

Signature of Patient or Guardian Date

08/11