

**AUTHORIZATION TO RELEASE DENTAL INFORMATION**

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| --- | --- |
| Patient Name: | DOB: |
| Release to: | Phone: |

*The execution of this form does not authorize the release of information other than the terms specifically*

*described below.*

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 condition described below

\_\_\_\_ 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 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.*

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| --- | --- |
| Patient Name: | Date: |
| Patient/Guardian Signature: |
| Relation to patient:  |