



Authorization to Release Dental Records

Release Details:

Patient information:

Full Name: _____ Birth date: _____

Health Care Provider Information:

Provider Name: _____

Address: _____

City, State, ZIP Code: _____

Information Requested:

- Copy of complete dental chart
- Copy of dental radiographs
- Other: _____

Dates Covered:

- All treatment rendered by this office or doctor
- Limited to treatment dates and for the following conditions: _____

Purpose for Which Information is To Be Used:

- Transfer of records
- Second opinion
- Other: _____

Authorization:

I request and authorize the above-named doctor or health care provider to release the information specified above 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): drug abuse, alcoholism or alcohol abuse, sickle cell anemia, and psychological or psychiatric conditions, if any.

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

Date

Printed Patient Name