Caring Smiles
You'll love our care and your smile will show it!

# Authorization to Release Dental Records

**Release Details:**

**Patient information:**

Full Name: _____ Birth date: _____

**Health Care Provider Information:**

Provider Name: _____

Address: _____

City, State, ZIP Code: _____

Email: _____

Phone: _____

**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: _____

**Please send records to: records@caringsmilesdental.com**

**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**