# AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

TO: _____ PATIENT NAME:_____ FAX:

_____ DOB: _____ SSN:_____ RELEASE

TO:_____

_____*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: DATES COVERED:**

*Limited to treatment dates and for condition described below:

_____Copy of complete dental chart
_____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, but in any event: on_____(date supplied by patient; or_____ if revoked in writing by patient; or_____180 days from the date hereof; or_____under the following conditions:_____.*

**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 Name (Print)

_____ _____ Person authorized to sign for patient State how authorized

_____ _____ Signature Date