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AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

To: Patient Name: Release To:

I request and authorize the above named doctor or healthcare provider to release the information specified below to the organization, agency or individual named on the request. I understand that the information to be released includes information regarding the following conditions:

_____Drug abuse, if any _____Alcoholism or alcohol abuse, if any

_____Sickle Cell anemia, if any _____Psychological or psychiatric conditions, if any

INFORMATION REQUESTED DATES COVERED

_____Copy of complete dental chart _____All treatment rendered in this office or this Dr.

_____Copy /email dental x-rays _____Limited to treatment dates/conditions

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED

_____Transfer of records _____Second Opinion _____Other

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given 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.Without 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 here of or under the following conditions

OTHER CONDITIONS: A copy of this authorization or my signature there on may not be used with the same effectiveness as an original.

Patient Signature_____Date_____

Person authorized to sign for patient. How authorized _____