



520 w. Brown St. Suite B • Wylie, TX 75098 972-468-9189

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: _____

EMAIL: _____ DOB: _____

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:

- Copy of complete dental chart
- Copy of dental x-rays
- All treatment rendered
- Others (e.g. models—describe) _____

*Limited to treatment dates below: _____

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: _____.

Patient Name (Print)

Person authorized to sign for patient

Signature

Date

