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Authorization to Release Dental Information

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

PATIENT NAME: _____ **DOB:**_____

RELEASE RECORDS TO:

Person, Doctor or Practice Name):_____

ADDRESS:_____

_____

PHONE #:_____

EMAIL ADDRESS:_____

I request and authorize the above-named doctor or health care provider to release dental x-rays to the organization, agency or individual named on this request.

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.

_____
Requestor's Name (Printed)

_____ _____
Requestor's Signature Requestor's Relationship to Patient