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AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

PATIENT NAME:

RELEASE TO:

DOB:

ADDRESS:

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):

* 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 by this doctor

___ Copy of dental x-rays

___ Limited to treatment dates & for conditions described below

___ Other (e.g. models – describe)

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

___ Transfer of records

___ Second Opinion

___ Other

___ Claim evaluation

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. 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 X 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: X may, _____ may not be used with the same effectiveness as an original.*

PATIENT NAME (PRINT)

PERSON AUTHORIZED TO SIGN FOR PATIENT:

PATIENT SIGNATURE

STATE HOW AUTHORIZED

DATE