Authorization for the Release of Dental Records

I, hereby authorize _____, to release the dental records of

_____(patient's name) to

_____
(name of dentist, physician, or patient's representative)

_____
(e-mail address or fax number)

***Our radiographs are digital and can only be sent by e-mail if they are to be used for treatment at another dental clinic.**

Any and all information in the possession of the dental clinic may be released, except as specifically provided below.

_____

_____

This authorization is effective now and will remain in effect until _____ (date).
I understand that I may receive a copy of this authorization.

_____
Name (Please Print)

_____ _____
Signature Date

If not signed by the patient, please indicate relationship:

O Parent or guardian of minor patient

O Guardian or conservator or an incompetent patient

O Beneficiary or personal representative of deceased patient