Client Name: __________________________Release to: _______________________________
(Print)

AUTHORIZATION TO RELEASE DENTAL INFORMATION

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 conditions:

______ Drug Abuse, if any

______ Other

______ Alcoholism, or alcohol abuse, if any

______ Psychological or psychiatric conditions

INFORMATION REQUESTED:

______ Copy of complete chart

______ Copy of Dental X-Rays

______ Other (e.g., models – describe)

DATES COVERED:

______ All treatment rendered in this office or by this doctor

______ Limited to treatment dates & for conditions described below

PURPOSES OR NEED FOR WHICH INFORMATION IS TO BE USED:

______ Transfer of records

______ Other

______ Second opinions

______ 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 client); or ____revoked in writing by client; or ___180days from the date hereof; or ___under the following conditions:

OTHER CONDITIONS: A copy of this Authorization or my signature thereon ____may, ____may not be used with the same effectiveness as an original.

DATE______________________________________

____
Person authorized to sign for client

____
CLIENT SIGNATURE

____
(State how authorized)

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