Authorization to Release Dental Information

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

To:

Patients:

Release To: **Arnold Smiles**
124 Richardson Crossing
Arnold, MO 63010
(636)464-6444 (office)
(636)464-6465 (fax)

I request that the above name doctor or health care provider release the information specified below to the organization, agency or individual named on the request.

Information Requested:
__ XX_Copy of complete dental chart (including periodontal charting)
___X_ Copy of dental x-rays (BW within one year, FMX/panoramic within 5 years)
_____History of treatment rendered by dentist or staff
_____Other:_____

Purpose Or Need For Which Information Is To Be Used:
__X___Transfer of records _____Second opinion _____Other

Authorization: I certify that this request has been made voluntary and 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 the 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___xx___date supplied by patient: or_____if revoked in writing by patient: or_____180 days from the date hereof: or under the following conditions:

A copy of this authorization or my signature thereon may be used with the same effectiveness as an original.

Print Patient Name	**Print Person Authorized To Sign For Patient (If Not Patient)**
Patient or Authorized Person Signature	**Date**