AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Karen L. Kucharski, D.M.D. to release/receive the following information from the records of:

Patient Name:_____SSN:_____DOB:_____

Address:_____City:_____State:_____Zip:_____

Telephone Number:_____

To be released to:
Name:_____Telephone Number:_____

Address:_____City:_____State:_____Zip:____

Information to be released: (Check all that apply)
BWX taken within 1 year
FMX taken within 5 years
Perio Chart

Date of Last Exam:_____
Date of Last Cleaning:_____

Type of cleaning: Child Prophy Adult Prophy Perio Maintenance

Recommended Recall Frequency (please circle the appropriate frequency)
3 month 4 month 6 month 12 month

I PLACE NO LIMITATIONS ON THE RELEASE OF HISTORY OF ILLNESS OR DIAGNOSTIC OR TREATMENT INFORMATION, INCLUDING BUT NOT LIMITED TO ANY INFORMATION CONTAINED IN MY RECORD CONCERNING TREATMENT FOR ALCOHOL, DRUG ABUSE OR DEPENDENCY, MENTAL ILLNESS, PSYCHIATRIC OR PSYCHOLOGICAL ILLNESS OR AIDS.

I understand that I am waiving my rights to privacy by releasing my information to the parties listed above and this information may be re-disclosed to the receiving party.

Signature_____Date_____

If not signed by the patient please indicate relationship:
Parent or guardian of minor patient
Guardian or conservator of an incompetent patient
Beneficiary or personal representative of deceased patient