AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize and request you release a complete copy of my dental records to:

Divine Dental Smile
Monica T Lee DDS FAGD
Jennifer E McClanahan DMD
6350 Mae Anne Ave Suite 1
Reno, NV 89523

Telephone: (775)787-2600
Fax: (775)787-2602
Email: divinedentalsmile@yahoo.com

Name of Patient_____
please print clearly

Address of Patient_____

Name, Address, Phone and Fax of dental office from whom your are requesting records:

_____

_____

_____

I understand that I can revoke this authorization by providing written notice to the office manager of Divine Dental Smile at the address listed above. I also understand that if the information has already been released upon this authorization, that revocation will not be valid.

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 redisclosed to the receiving party.

Signature of Patient
or Authorized
Representative_____
Date

Printed Name of
Representative
if applicable _____