Authorization to Release Dental Information

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

To (current dentist) _____

Patient_____

Date of Birth _____

Release to _____

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 in this request. I understand that the information to be released includes information regarding the following condition(s):

_____ Drug Abuse, if any
_____ Sickle Cell Anemia, if any
_____ Alcoholism or alcohol abuse, if any
_____ Psychological or psychiatric condition, if any

Information requested:

_____ Copy of Complete dental chart
_____ Copy of dental radiographs
_____ Other (models,etc..) describe:_____

Purpose or need for which information is to be used:

_____ Transfer of records
_____ Second Opinion
_____ Other

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 _____ if revoked in writing by patient; or 180 days from the date hereof; or _____ under the following conditions:

List conditions: _____
Other conditions: A copy of this authorization, or my signature thereon may _____ may not _____ be used with the same effectiveness as an original.

Signature _____ Date _____

General Dental Release

Please provide me with copies of all of my dental records, x-rays, medication sheets, interpretations of tests, and progress notes pertaining to my dental treatment. I understand that the custodian of my actual dental record is my dentist. I understand that the information contained in the record belongs to me. I agree to accept copies of such records and to pay any fee(s) for duplication as required.

Patient Signature _____ Date _____

Date of Birth _____