
P A T I E N T N U M B E R

NAME _____
Last First Date of Birth

PATIENT'S ADDRESS _____
Street City State Zip

HOME TELEPHONE _____ ALTERNATE TELEPHONE _____

I hereby authorize _____
Doctor's Name/Provider
and whomever he/she may designate to release information in the Medical Record of the patient named above.

INFORMATION TO BE RELEASED (check all that apply):

- Entire Record
- Medical/Dental History
- Consent Forms
- Dentist/Hygienist Notes
- X-Rays
- Other: _____
- Examination Notes
- Treatment Plans

INFORMATION LIMITATIONS (list any restrictions on information to be released):

PURPOSE OF INFORMATION RELEASE:

- Continuing Care
- Legal
- Copies for own use
- Transfer to another provider
- Other _____

I authorize the release of the information requested above to the following party:

NAME _____ ATTENTION OF _____

ADDRESS _____
Street City State Zip

TELEPHONE # _____ ALTERNATE TELEPHONE # _____

I give permission to the office of the provider listed above to release the requested Medical Information to the party listed. I am aware that the office of the provider cannot control how the recipient uses or shares the released information.

Information will not be released without a valid signature below. This authorization will expire 90 days from the signature date. I may also cancel this authorization in writing at any time. Neither cancellation nor failure to execute this authorization will affect my receipt of services. I understand that my cancellation will not have any effect on information released before a cancellation letter is received by the provider.

Patient or Guardian's Signature _____ Date _____

Dentist's Signature _____ Date _____

Witness's Signature _____ Date _____

A photocopy of this release is as valid as the original and must be given to the signing Patient or Guardian.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION