Authorization to Release Dental Information

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

Patient Name ____________________	Date of Birth ____________________
Patient Name ____________________	Date of Birth ____________________
Patient Name ____________________	Date of Birth ____________________
Patient Name ____________________	Date of Birth ____________________

Release To: ____

E-Mail Address ____ Fax Number _______________

I request and authorize the named doctor or health care provider to release the information specified to the organization, agency or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

Information Requested:
*Limited to treatment dates and for
__ Copy of complete dental chart condition described below:
__ Copy of dental x-rays
__ All treatment rendered
__ Other (e.g. models -describe)

Purpose or need for which information is to be used:
__ Transfer of Records
__ Second Opinion

____
Parent / Guardian

____
Relationship to Patient(s)

____
Signature

__________________.
Date

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