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 ____________________

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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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