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AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

Patient Name: ____
DOB: ____
SSN: ____

Release Records 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 names on this request. I understand that the information to be released included information regarding the following condition(s):

*Drug Abuse, in any
*Sickle Cell Anemia, if any
*Alcoholism or alcohol abuse, if any
*psychological or Psychiatric conditions, if any

INFORMATION REQUESTED:
____Copy of complete dental charge $25.00 Duplication Fee
____Copy of dental x-rays (there is a minimal duplication charge of $10.00 for all x-rays)
____Other-Describe ____
____
____

DATES COVERED:
____All treatment rendered in this office or by this doctor
____ Limited to treatment dates and for conditions described below:
____

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:
____Transfer of records ____Second Opinion____Other

SIGNATURE: ____ **DATE:** __________

PLEASE BE AWARE WE REQUIRE 7 BUSINESS DAYS TO RESPOND.