DENTAL RECORDS RELEASE FORM

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

AUTHORIZES:

_____

TO DISCLOSE TO: ☐ Self ☐ Dental Provider ☐ Other _____
Delivery options ☐ mail ☐ delivery ☐ email ☐ fax ☐ pick up *(please fill in below)*

To be picked up by, I hereby authorize _____ to pick up my records. (Photo ID required.)

Send to: _____
Name of Health Care Provider / Plan / Other/ Myself

_____
Address

PHONE: _____ FAX # _____

EMAIL : _____

Only information from the past five (5) years will be disclosed. Unless dates filled in below.
From: _____ *To* _____

When transferring information to another dental office we only send current x-rays (bitewing x-rays, full mouth x-rays & panorex) within the last 5 yrs and treatment dates for prophy's (cleanings) – exams – scale & root planning. To send just this basic information described above please check here ☐

If you want us to release other information then please mark below.
INFORMATION TO BE DISCLOSED:
Treatment plan ☐ Radiology films/images ☐ All billing records ☐

Specific records/information as follows: _____

_____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED:
_____

EXPIRATION: This Authorization is good for one year unless dates filled in below
From: _____ *To* _____

SIGNATURE OF PATIENT / LEGAL REP:

_____ DATE: _____
If signed by a person other than the patient, complete the following: Individual is: ☐ parent* legal guardian
☐ legally incompetent ☐ incapacitated deceased ☐ next of kin / executor of deceased

By signing, I understand that the information released per this authorization, if redisclosed by the recipient, is no longer protected by _____