DENTAL RECORDS RELEASE FORM

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Authorizes:

Name of Practice: _____

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:

Office Name: _____ Phone: _____

Fax: _____ Email: _____

Only information from the past (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 and panorex) within the last 5 years and treatment dates for prophy's (cleanings), exams, and scaling & root Planning.

To send just this basic information described above please initial here ____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED:

_____

Signature of Patient/Legal Rep:

Name: _____ 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/executer of deceased.

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