AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

TO: _____ PATIENT NAME: _____

FAX: _____ DOB: _____

RELEASE TO: _____

Please include email: _____

I request and authorize the above-named doctor or health care provider to release the information specified below 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:

_____ Copy of complete dental chart **_____ Copy of dental x-rays**

_____ All treatment rendered **_____ Copy of treatment notes from _____**

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:

_____ Transfer of Care **_____ Other, please explain _____**

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken to comply with it. With my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, or if revoked in writing by patient; or as requested on the following date below or 1 year from the date hereof.
Date (optional):_____

_____
Patient Name (Print)

_____ _____
Person authorized to sign for patient if minor pt. Relationship to patient

_____ _____
Signature Date

SEND INFORMATION TO: **Fond du Lac Dental**
927 Trettel Lane
Cloquet, MN 55720
Phone: 218-878-2163 Fax: 218-878-2168 Secure Email: HSDdental@fdlrez.com