

DENTAL RECORDS RELEASE FORM

Patient Name: _____ Date of Birth: _____

Patient Information:

Address: _____

Phone Number: _____

Email Address: _____

Release Authorization:

I hereby authorize the release of my complete dental records, including but not limited to charts, radiographs (x-rays), treatment records, billing information, and any other pertinent information to the recipient specified below. This authorization is valid for all information created prior to the date of this form and any future information until this authorization is revoked in writing.

Recipient Information (to whom records will be released):

Name/Organization: _____

Address: _____

Phone Number: _____

Fax Number: _____

Purpose of Disclosure:

The purpose of this disclosure is to provide the recipient with necessary dental information for continued treatment, insurance claims, legal documentation, or personal records.

Expiration and Revocation:

This authorization will remain in effect until revoked in writing by the patient. Revocation will not affect disclosures made prior to receipt of the revocation.

Acknowledgement and Signature:

I understand that my dental records may contain information about communicable diseases, including but not limited to HIV/AIDS and hepatitis, and I consent to their release. I understand that once my records are released, the recipient may redisclose them and the information may no longer be protected by federal privacy laws.

Patient or Legal Guardian Signature: _____

Print Name: _____

Relationship to Patient (if Legal Guardian): _____

Witness Signature: _____

Print Name: _____

FOR OFFICE USE ONLY:

The patient was provided with a copy of this authorization. The request for records was received and processed in accordance with applicable laws and office policies.

Staff Member Name: _____

Date Processed: _____

Patient or Legal Guardian Signature

Witness Signature

Signature: _____

Signature: _____

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