DENTAL RECORDS RELEASE FORM

PATIENT INFORMATION:

Name: ____ Date of Birth: _____________________

AUTHORIZES:

Office Name __________________________ **Number**__________________ **Email** _________________

To send records to

Office Name __________________________ **Number**__________________ **Email** _________________

TO DISCLOSE TO: ☐Self ☐ Dental Provider ☐ Other ____________________
Delivery options ☐ mail ☐ email ☐ fax ☐pick up

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

____
Address

PHONE: _______________________________ FAX # ________________________________

EMAIL : ____

When transferring information to another dental office we only send current x-rays (bitewing x-rays, full mouth x-rays & panorex)
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:
____

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