AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

PT Name:_____ **DOB:**_____

I request and authorize **Family First Dental** to release ( ) or obtain ( ) the information specified below to or from the organization, agency or individual named on this request. I understand that the information to be released or obtain includes information regarding the following condition(s):

Information requested:

_____ Copy of complete dental chart

_____ Copy of dental x-rays

_____ All treatment rendered

_____ Others (e.g. models---describe)

Dates Covered:

*Limited to treatment dates and for condition described below:

_____

_____

TO DISCLOSE TO: ☐Self ☐ Dental Provider ☐ Other _____

Delivery options ☐ mail ☐ delivery ☐ email ☐ fax ☐pick up *(please fill in below)*

From / Sent to:_____

Name of health care provider | Plan | Other | Myself

_____

Address

Phone Number:_____ Fax:_____

Email:_____

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, but in any event: on _____ (date supplied by patient; or _____ if revoked in writing by patient; or _____ 180 day from date hereof; or _____ under the following conditions:_____

_____**OTHER CONDITIONS:** A COPY of this authorization or my signature there on ____ may, or _____ may not be used with the same effectiveness as an original.

_____ _____

Patient Signature or Legal Representative Date

_____ _____

Legal Representative Print name Relationship