



Authorization to Release Dental Records

PATIENT INFORMATION:

Full Name _____

Street Address _____

City, State, Zip Code _____

Date of Birth: ____/____/____ Phone: ____-____-____

SEND RECORDS TO:

Name of Dentist, Physician, or Agency _____

Street Address _____

City, State, Zip Code _____

Phone: ____-____-____ Fax: ____-____-____

Send via e-mail: _____

INFORMATION TO BE DISCLOSED:

- Exam & Treatment Notes Date: _____
- Radiographs (X-rays) Date: _____
- Treatment Plan Date: _____
- Other (specify): _____

PURPOSE(S) FOR DISCLOSING INFORMATION:

- Continuation of Care/Consultation
- Attorney Inquiry/Legal Matter
- Insurance Claim
- Other (specify): _____

I understand that all information I hereby authorize to be obtained will be held strictly confidential and cannot be released without my written consent. I understand that this authorization will remain in effect until revoked by me in writing.

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time by submitting my request in writing.

Print Name (Patient/Guardian): _____

Signature (Patient/Guardian): _____ Date: _____

Signature of Witness: _____ Date: _____

1579 Cherry Valley TPKE · Skaneateles, NY 13152 · P: (315) 685-5874 · F: (315) 685-1814 · www.SmilesOfSkaneateles.com