

Authorization to Release Dental Information

FROM Sunnyside Dentistry

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

Patient(s) Name _____ Date of Birth _____

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Release To:

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 in this request. I understand that the information to be released includes information regarding the following condition(s):

Information requested:

_____ Copy of perio charting
_____ Copy of dental radiographs

Purpose or need for which information is to be used:

_____ Changing dentist
_____ Second Opinion
_____ Other

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. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event on _____ if revoked in writing by patient: or 180 days from the date hereof: or _____ under the following conditions:

List conditions:

Other conditions: A copy of this authorization, or my signature thereon may _____ may not _____ be used with the same effectiveness as an original.

Signature _____ Date _____