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AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

I, *(Patient Name)* ____,

DOB: _____/_____/_________, hereby request and authorize

(doctor/practice) ____

(phone) __________________________ *(email)* ____

(address) ____

to release my dental records or information regarding my dental records to:

Riverside Family Dental, P. A.
(Contact information on letterhead)

Purpose for which information is to be used:

____ Transfer of Records ____ Second Opinion

____ Other, please explain ____

OTHER CONDITIONS

A copy of this Authorization or my signature thereon ☐ *may* *or* ☐ *may not* be used with the same effectiveness as an original:

____
Patient Name (Print)

____ ________________________
Signature *Date*

____ ________________________
Person authorized to sign for patient *Relationship to patient*

…MAKING A DIFFERENCE IN OUR PATIENTS' LIVES AND IN OUR COMMUNITY!