AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

Patient: _____ Release to: H~Dentistry PLLC

DOB: _____ c/o Dr Bruce Hoggan DDS

Provider: _____ 225 Callahan Ave. Parachute, CO 81635

_____ (970) 285-7748 om.hdentistry@gmail.com

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 on this request. I understand that the information regarding the following condition(s):

_____Drug Abuse, if any _____Alcoholism or alcohol abuse, if any

_____Sickle Cell Anemia, if any _____Psychological or psychiatric conditions, if any

INFORMATION REQUESTED:

DATES COVERED:_____ to _____.

_____Copy of complete dental chart _____ All treatment rendered in this office or by this doctor

_____Copy of dental x-rays _____ Limited to treatment dates and for the following conditions:

Purpose(s) or need for which information is to be used:

_____ Patient is moving _____ Second Opinion _____ Insurance Claim

_____ Other (explain) _____

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 _____ (date supplied by patient); or __x_ revoked in writing by patient; or ___ 180 days from the date hereof; or _____ under the following conditions:

OTHER CONDITIONS: A copy of this Authorization or my signature thereon: __x_ may, _____ may not be used with the same effectiveness as an original.

Date: _____

Patient Printed Name: _____ Patient Signature: _____

Person Authorized to sign for patient: _____

Relationship to patient: _____