

AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

PATIENT NAME: _____ DATE OF BIRTH: _____

RELEASE RECORDS FROM:

RELEASE RECORDS TO:
Mesa Ridge Dental Center
6980 Mesa Ridge Parkway, #200
Fountain, CO 80817

INFORMATION REQUESTED:

____ Copy of complete dental chart ____ Copy of dental x-rays ____ Other

DATES COVERED:

____ All treatment rendered in this office ____ Limited to treatment dates & for conditions described below:

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

____ Transfer of Records ____ 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, until revoked in writing by patient.

OTHER CONDITIONS: A copy of this Authorization or my signature thereon may be used with the same effectiveness as an original. By signing this Authorization, I agree to pay any and all costs that may be incurred in the duplication of my records.

Patient or Responsible Party Signature

Date

Relationship to Patient

Date