

Dental Records Release Authorization Form

Patient Information

- Full Name: _____
 - Date of Birth: ____ / ____ / ____
 - Phone Number: _____
 - Address: _____
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Records To Be Released

- Complete dental records
 - X-rays only
 - Treatment history
 - Other: _____
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Release Records To / From (circle one):

- Name of Provider/Office: _____
 - Address: _____
 - Phone: _____ Fax: _____
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Purpose of Release

- Continuing care / Transfer of care
 - Insurance
 - Personal use
 - Legal matter
 - Other: _____
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Authorization

I authorize [**Your Practice Name**] to release the dental records indicated above. I understand that:

- This release is valid for one year from the date signed unless revoked in writing.
 - Revocation must be submitted in writing to the dental office.
 - Information disclosed under this authorization may be subject to re-disclosure by the recipient.
 - I may request a copy of this completed form.
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Patient / Legal Representative Signature: _____

Printed Name: _____

Relationship to Patient (if not self): _____

Date: ____ / ____ / ____

Office Use Only

- Processed by: _____

Date released: ____ / ____ / _____

Method: Mail Fax Email Pickup