MUSS FAMILY DENTISTRY

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AUTHORIZATION TO RELEASE DENTAL INFORMATION

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____* _____* ____ _____
Last First MI Preferred Name

Title: _____ **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ **Prev. Visit:** _____ **Email Address:**

_____

Phone: _____* _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____* _____
Address 1 Address 2

_____* _____* _____-____*
City State Zip Code

TO: _____

FAX NUMBER: _____

ADDRESS:

_____

_____

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 to be released includes information regarding the following condition(s):

Information Requested:

☐ Copy of Complete Dental Chart ☐ Copy of Dental Records ☐ All Treatment Rendered

Dates Covered: _____

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:

◯ Transfer of Records ◯ Second Opinion ◯ Other

if other, please explain below

_____

_____

_____

_____

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.

Signature _____ **Date** _____

Response Date: _____