CHANHASSEN DENTAL

Authorization to Release Dental Records

PATIENT INFORMATION:

Full Name

Street Address

City, State, Zip Code

____/____/____ Date of Birth

____-____-____ Phone

SEND RECORDS TO:

Self or Name of Dentist, Physician, Agency, Etc.

Street Address

City, State, Zip Code

____-____-____ Phone

____-____-____ Fax

☐ Send via e-mail: office@chanhassendental.com

INFORMATION TO BE DISCLOSED:

- ☐ Exam & Treatment Notes Date:_____
- ☐ Radiographs (X-rays) Date:_____
- ☐ Treatment Plan Date:_____
- ☐ Other (specify):_____

PURPOSE(S) FOR DISCLOSING INFORMATION:

- ☐ Continuation of Care/Consultation
- ☐ Attorney Inquiry/Legal Matter
- ☐ Insurance Claim/Application
- ☐ Other (specify):_____

I understand that all information I hereby authorize to be obtained will be held strictly confidential and cannot be released without my written consent. I understand that this authorization will remain in effect until revoked by me in writing.

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time by submitting my request in writing.

Print Name (Patient/Guardian): _____

Signature (Patient/Guardian): _____ Date: _____

Signature of Witness: _____ Date:_____