CHAPMAN DENTAL GROUP

Keep Smiling FAMILY DENTISTRY

AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

PATIENT NAME: _____

DOB: _____ **SSN:** _____

RELEASE TO: _____

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: DATES COVERED:

*Limited to treatment dates and for
_____Copy of Any Test Results
_____Copy of Medical History
_____Copy of complete dental chart condition described below:
_____Copy of dental x-rays
_____All treatment rendered
_____Others (e.g. models—describe) _____

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:

_____Transfer of Records _____Second Opinion

_____Other, please explain _____

INFORMATION RELEASED TO By Email or Mailed to :

Name: _____

Address: _____

Phone: _____ Fax: _____

_____
Patient Name (Print)

_____ _____
Person authorized to sign for patient State how authorized Date