Lake Jeanette
ORTHODONTICS & PEDIATRIC DENTISTRY
A great place to grow a smile.

Authorization to Release Dental Records

Please Send Records To:

Name of Provider: _____

Name of Practice: _____

Address: _____

Phone: _____Fax: _____

€ Send Via Email: _____

For:

Name of Patient: _____ Date of Birth: ____/____/_____

Name of Patient: _____ Date of Birth: ____/____/_____

Name of Patient: _____ Date of Birth: ____/____/_____

Name of Patient: _____ Date of Birth: ____/____/_____

Information Requested:
€ Copy of complete dental chart
€ Copy of dental x-rays
€ Other: _____

Purpose(s) for Disclosing Information:
€ Transfer of Care
€ Attorney Inquiry/ Legal Matter
€ Insurance Claim/ Application
€ Other : _____

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 also 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

Authorizations signed by a legal representative must include a copy of the guardianship paper or a power of attorney.