Authorization to Release Personal Health Information

I, _____, authorize
(Patient/Legal Guardian name)

_____
(Name of facility releasing the records)
to release copies of my dental records with respect to any dental care and treatment to:

_____
(Name and address to whom the records will be sent)

I understand that the specific type of information to be disclosed may include a detailed report of examinations, findings, treatments, prognosis, and copies of any/all other records, including X-rays, which pertain to me.

I hereby release _____ from all legal responsibility or legal liability
(Name of facility releasing the records)
that may arise from the release of such information. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire ninety (90) days after the date below.

A reproduced copy of this authorization shall be as valid as the original.

Patient printed name: _____ Date of birth_____

Patient signature: _____
(Patient/Legal Guardian)

Relationship to patient: _____

Patient address: _____

Date: _____

Clinic card #: _____

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