DENTAL RECORDS RELEASE FORM

PATIENT INFORMATION:

Name (please print): ______________________________ Date of Birth: ______________

The above-named patient authorizes ______________________________

(*Name of Practice*)

to disclose: ☐ **Clinical Records and X-Rays** for the past 3 years **OR** ☐ the following **Specific Records** as follows (please describe):

____

To ☐ Self

OR ☐ Other ______________________________

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(*Name / address of individual or company-if pickup requested, Photo I.D. will be required at time of pickup*)

OR ☐ Dental Provider Name: ______________________________

Address: ______________________________

Phone: ______________ Email: ______________

(*Name, address, phone number and email of Dental Provider*)

PLEASE NOTE: When transferring information to another dental office, our customary practice is to send only current x-rays (bitewing x-rays, full-mouth x-rays and panorex) within the last five (5) years and treatment dates for prophy (cleaning) treatments, exams and scaling / root planing.

☐ ***Check here to send this basic information; if you want additional records transferred to Dental Provider, please check "Clinical Records" or "Specific Records" toward the top of this form).***

I DO NOT WANT THE FOLLOWING DISCLOSED: ______________________________

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Delivery Options

□ Mail - addressee and address: ______________________________

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□ Fax ______________ □ Email ______________

(*Fax Number*) (*Email Address*)

□ Pickup

□ Overnight Courier (*pre-paid, pre-addressed label must be provided to practice*)

SIGNTURE OF PATIENT / LEGAL REPRESENTATIVE

Signed: ______________________________ Date: ______________

Name (please print):

If signed by a person other than patient, complete the following:

Signer is: ☐ Parent of Minor Patient ☐ Legal Guardian ☐ Executor of Deceased Patient's Estate

□ Other (as described above)

FOR RECORD PICKUP ONLY:

Records retrieved / picked up by: (print name) ______________________________

Witnessed by (Staff Member to print / sign name) ______________________________

Date of pickup: ______________

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by relevant federal and/or state law. If I have requested to receive health information electronically, I understand that unencrypted email is not secure and therefore may be intercepted by others. I also understand that email may be misdirected and forwarded to unintended recipients. By choosing to receive my health information by email, I am accepting these risks.