appletree dental
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Thornton, Colorado 80241
Phone: 720-872-2892
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AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

PATIENT NAME:_____ **DOB:**_____

RELEASE FROM:

_____

Office Name **Address, City, State Zip Code** **Email Address**

RELEASE TO:

_____

Office Name **Address, City, State Zip Code** **Email Address**

INFORMATION REQUESTED:

_____ Copy of Complete Dental Chart _____ Copy of Complete Dental X-rays

DATES COVERED:

_____ All treatment rendered in this office or by this doctor

_____ Limited to treatment dates and for conditions described below

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:

_____ Transfer of Records _____ 2nd Opinion _____ Other:_____

AUTHORIZATION

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action had already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure.

_____ _____ _____

Patient Name **Patient Signature** **Date**

OR _____ _____ _____

Parent/Guardian of Patient **Signature of Parent/Guardian** **Date**