Littleton Dental

AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

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):

_____ Drug Abuse, if any
_____ Sickle Cell Anemia, if any
_____ Alcoholism or alcohol abuse, if any
_____ Psychological or psychiatric conditions

INFORMATION REQUESTED:

_____ Copy of complete dental chart

_____ Copy of dental x-rays

_____ Other (e.g. models-describe) _____

DATES COVERED:

_____ All treatment rendered in this office by this doctor

_____*Limited to treatment dates & for conditions described below:

PROPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

_____ Transfer of records
_____ Other _____
_____ Second opinion

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 has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event: on _____ (date supplied by patient); or _____ if revoked in writing by patient; or _____ 180 days from the date hereof; or _____ under the following conditions:*

OTHER CONDITIONS: *A copy of this Authorization or my signature thereon: _x___may, _____ may not be used with the same effectiveness as an original.*

PATIENT NAME (PRINT): _____
PERSON AUTHORIZED TO SIGN FOR PATIENT: _____

DATE: _____ PATIENT SIGNATURE: _____