Emergency DENTAL CARE USA®

Authorization to Release Dental Records

Patient Information:

_____
Full name

_____
Street Address

_____
City, State, Zip Code

____/____/_____
Date of Birth

Send Records To:

_____
Self or Name of Dentist, Physician, Agency, Etc.

_____
Street Address

_____
City, State, Zip Code

____-_____-_____
Phone Fax

☐ Send via e-mail:_____

Circle the Information you are authorizing to be disclosed:

Exam & Treatment Notes
Radiographs (X-rays)
Other (specify):_____

Circle the Purpose(s) for disclosing Information:

Continuation of Care/Consultation
Insurance Claim/Application
Other (specify):_____

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 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:_____