AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

RETURN FORM TO RECORDS@SMPDTN.COM

Date: _____

Patient Name(s):	Release to:
Date of Birth(s):	Address and email:

INFORMATION REQUESTED

- ☐ Summary of dental chart
- ☐ E-mail of most recent x-rays
- ☐ Other _____

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED

- ☐ Transfer of records to new provider
- ☐ Other _____

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

Authorized Signature _____ Date: _____

Relationship to patient _____

OFFICE USE ONLY

Date release requested _____ Processed by_____

Date records released _____

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