Authorization To Release Dental Records

Woodburn MODERN DENTAL

PATIENT INFO	
Name:	Birth Date:
Address:	Phone:
City/State/Zip:	Email Address:

RELEASE TO

I hereby authorize the doctors and staff of Woodburn Modern Dental to release records concerning my dental health to:

Office Name:	Phone Number:
Address:	Fax Number:
City/State/Zip:	Email Address:

INFORMATION TO BE RELEASED

_____ Copy of complete dental chart
_____ Copy of dental x-rays
_____ All treatment rendered

Dates Covered
From: _____
To: _____

PURPOSE OF NEED FOR WHICH INFORMATION IS TO BE USED

_____ Transfer of Records
_____ Second Opinion
_____ Other (please explain): _____

AUTHORIZATION

Once doctors or staff of Woodburn Modern Dental give out the information that I want released, I know that doctors or staff of Woodburn Modern Dental have no control over the information. The individual or organization that I authorize to receive the information might re-disclose it. Federal or state privacy laws no longer protect the information.

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. With my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure.

_____
Print Name of Patient or Person Authorized to Sign for Patient

_____ _____
Signature of Patient or Person Authorized to Sign for Patient — Date

FOR COMPLETION BY WOODBURN MODERN DENTAL

_____ _____
Fulfilled By — Date