HESTER PEDIATRIC DENTISTRY P.A.

AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

Patient Name:_____ DOB: _____ Phone Number:_____
Release To:_____
Via:
☐Email: _____
☐Mailing Address: _____

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):

INFORMATION REQUESTED:
☐Copy of complete dental chart
☐Copy of dental x-rays
☐All treatment rendered _____
☐Others (e.g. models— please describe)
DATES COVERED: _____ to _____

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:
☐Transfer of Record
☐Second Opinion
☐Other, please explain_____

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. With 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:*
_____.

Patient Name (Print): _____
Person authorized to sign for patient (Print Name): _____
State how authorized (relationship): _____
Signature: _____ **Date:** _____

For Office Use Only:

Date Processed: _____ **Processed by:** _____