Pennsylvania DENTAL

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____

Last First Middle

_____

Maiden Name Previously Married Name Date of Birth

I hereby request and authorize: Name _____

Address _____

City _____ State _____ Zip _____

Email _____

To send a copy of the following reports from the patient's record: ☐ X-Rays ☐ Perio Charting ☐ Full Dental Records

To be Released to: Name _____

Address _____

City _____ State _____ Zip _____

Email: _____

I acknowledge that data to be released MAY INCLUDE material that is protected by Federal Law that is applicable to ANY of ALL of the above.

My signature below authorizes release of all such information.

Signature of Patient or Responsible Party _____ Date _____

I, the above signed, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent will expire upon completion of the transaction and no later than ninety (90) days from the date signed unless otherwise stated herein.

To the party receiving this information: This information has been disclosed to you form the records, whose confidentiality is protected by Federal and/or State regulation prohibit you from making further disclosure of it without the specific written consent of the person to who it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

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