DENTAL RECORDS REQUEST AUTHORIZATION

Alcan Family Dental **Phone:** 907-562-4774 **Fax**: 907-561-2755 Scheduling@AlcanFamilyDental.com

- RECORDS REQUESTED FROM:

  FACILITY/DR: _____ Email: _____

  Fax: _____ Phone: _____

- RECORDS RELEASE TO:

  FACILITY/DR: _____ Email: _____

  Fax: _____ Phone: _____

I understand that the information to be released includes the following:

INFORMATION REQUESTED:
_____Copy of complete dental chart _____Copy of most current dental x-rays _____current Panorex/CBCT
_____All treatment rendered _____Others (e.g. models—describe)

DATES COVERED:
*Limited to treatment dates and for condition described: _____

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:
__Transfer of Records __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. This Authorization is valid for one year from the date signed unless revoked in writing or unless the records have already been released due to my request.*

_____ Patient Name (Print)

_____ Person authorized to sign for patient

_____ Signature

_____ Date (Admin only) Released on / / By _____