AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

Release To: 8580 Scarborough Dr, STE 105
Colorado Springs, Co 80920
Ph: 719-528-5577 fax:719-528-5621
Please email to: info@outstandingsmile.com

Patient Name:

DOB:

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).

_____Drug Abuse if any _____Alcoholism or alcohol abuse, If any
_____Sickle Cell Anemia, if any _____Psychological or psychiatric conditions, if any

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INFORMATION REQUESTED

_____Copy of Dental X-rays

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

_____Transfer of Records _____Second Opinion

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. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event: on_____ (date); or __X__ revoked in writing by patient; or _____180 days from the date hereof; or _____ under the following conditions:

OTHER CONDITIONS: A copy of this Authorization or my signature thereon: __X__ may, ___may not be used with the same effectiveness as an original.

_____ _____
PATIENT NAME (print) DATE

_____
PATIENT SIGNATURE OR PERSON AUTHORIZED TO SIGN FOR PATIENT

Esthetic Family Dentistry
8580 Scarborough Dr., Suite 105
Colorado Springs, CO 80920
719-528-5577
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