Montshire
pediatric dentistry

Authorization for Release of Dental Records

Patient Information

Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: ____ Zip: _____

I hereby authorize:

Dental Practice Name: **Montshire Dental**

Address: _____

Phone: _____ Fax: _____

To (check one):

☐ Release my dental records to:

☐ Request my dental records from:

Name of Facility/Doctor: _____

Address: _____

Phone: _____ Fax: _____

Information to be released (check all that apply):

☐ All dental records

☐ Treatment records from (dates): _____ to _____

☐ X-rays (please specify): _____

☐ Billing records

☐ Other (please specify): _____

Purpose of release:

☐ Continuation of care

☐ Personal use

☐ Legal

☐ Insurance

☐ Other: _____

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Authorization and Signature

I understand that this authorization is voluntary and that I may revoke it in writing at any time. The revocation will not affect any disclosures made prior to the receipt of the revocation. I understand that once the information is disclosed, it may no longer be protected by federal privacy regulations.

This authorization will expire 1 year from the date signed unless otherwise specified: _____.

Signature of Patient or Legal Guardian: _____

Printed Name: _____ Date: _____

Relationship to Patient (if not self): _____

Montshire Dental Office Use Only

Date Processed: _____ Processed By: _____

Notes: _____