AUTHORIZATION TO RELEASE INFORMATION FORM

DOWNTOWNE DENTAL GROUP
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Authorization to Release Information

Patient's Name:____
Date of Birth:____

I hereby authorize Downtowne Dental Group to (check one):

__X__ Obtain from the following
____ Release to the following

Name:____
Address:____
Contact Number:____

The documents to be released are described or listed as:___x-rays_____________
____

The records are required for the specific purpose of: ___transferring____________
____

I understand that my authorization will remain effective from the date of my signature until I contact the office to revoke this form. The information will be handled confidentially in compliance with all applicable federal laws. I understand that I may see the information that is to be sent and that I may revoke the authorization at any time by written, dated communication. I have read and understand the nature of this release.

Signature of Patient (Guardian):_________________________________
Date:____