Stonegate Dental
17021 Lincoln Avenue #B
Parker, CO 80134
T. (720) 851-7069
F. (720) 842-1024

AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

To: Patient Name: Release To:

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 conditions(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 complete dental chart

___Copy of dental x-rays

___Other (e.g. models – describe)

DATES COVERED:

___All treatment rendered in this office or by this doctor

___*Limited to treatment dates & for conditions described below:

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

___Transfer of Records ___Second Opinion

___Other ___________________________________

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 supplied by patient); or ____ 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: ___may, ___ not be used with the same effectiveness as an original.*

PERSON AUTHORIZED TO SIGN FOR PATIENT:

____
PATIENT NAME (PRINT)

___________ ___________________________________ ____
DATE PATIENT SIGNATURE

STATE HOW AUTHORIZED: _____________