HIPAA/Authorization for release of Dental records form

Patient: ________________________________

Patient address: ___________________________

Patient Phone number: ( )- - ____________

I give permission for Glenhaven Dentistry to send X-rays or information needed for further treatment with a specialist or release of records at patient request.
I give permission for Glenhaven Dentistry to provide X-rays and health information with the permission given by signing this form.
The permission would be for requested information only from medical or Dental care professionals.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.
I AUTHORIZE THE DISCLOUSURE OF MY DENTAL OR HEALTH INFORMATION AS DISCRIBED IN THIS FORM.

Date__________
Patient Signature___________________

If you are signing as a representative of the patient, describe your relationship to the patient and the source of authority to sign this form.

Relationship to Patient ___________Name__________________________
Source of Authority _________________________