725 River Road, Suite 204A, Edgewater, NJ 07020 | P: (201) 313-5437 | F: (201) 313-7163

Authorization to Release Dental Records

PATIENT INFORMATION:

_____
Patient's First and Last Name

_____ /_____ /_____
Patient Date of Birth

(_____) _____ - _____
Phone No.

_____
Street Address

_____
City State Zip

SEND RECORDS TO:

_____
Self or Name of Practice/Dentist/Physician

(_____) _____ - _____
Phone No.

_____
Email Address

Send Records Via: ☐ Email ☐ Regular Mail

INFORMATION REQUESTED:

☐ Copy of Dental X-rays
☐ History of All Dental Treatment Rendered
☐ Other: _____

PURPOSE(S) FOR DISCLOSING INFORMATION:

☐ Consultation with Specialist
☐ Transfer of Records
☐ Other: _____

I acknowledge that all information I hereby authorize to be obtained be held strictly confidential and cannot be released without my written consent. I understand that this authorization will remain in effect until revoked by me in writing.

Additionally, although we send records via a secured email account, there may be some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. Please select one of the options below regarding email communication containing patient information and dental records via email.

☐ I consent to receiving the above requested information via email
☐ I do not consent to receiving the above requested information via email

Print Name of Parent/Guardian _____

Signature of Parent/Guardian _____ Date _____