AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

Patient Name: _____ **DOB:** _____

I hereby authorize release of my health/dental information to the individual/organization named below for the reasons:

Records to be released to: _____

Email:_____

Records to be sent from: _____

Email: _____

Information to be released:

- ☐ All Available X-Rays
- ☐ Other (please specify):

_____

_____

I understand that this authorization will be valid until revoked in writing. I understand that the information disclosed in relation to this authorization may be redisclosed by the recipient and could no longer be subject to protection by HIPAA privacy rules. I understand that I may receive a copy of this authorization upon request.

Signature: _____ **Date**: _____

Relationship to patient if not signed by patient: _____

DISCLAIMER: If any of the information above is incorrect/false, it may delay the process.