

# **DENTAL RECORDS RELEASE FORM**

**PATIENT INFORMATION:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**AUTHORIZES: Choice One Dental**

**TO DISCLOSE TO:**  Self  Dental Provider  Other \_\_\_\_\_  
Delivery options  mail  delivery  email  fax  pick up (*please fill in below*)

To be picked up by, I hereby authorize \_\_\_\_\_ to pick up my records. (Photo ID required.)

Send to: \_\_\_\_\_  
Name of Health Care Provider / Plan / Other/ Myself

Address

PHONE: \_\_\_\_\_ FAX # \_\_\_\_\_

EMAIL : \_\_\_\_\_

*Only information from the past five (5) years will be disclosed. Unless dates filled in below.*

*From: \_\_\_\_\_ To \_\_\_\_\_*

When transferring information to another dental office we only send current x-rays (bitewing x-rays, full mouth x-rays & panorex) within the last 5 years and treatment dates for cleanings – exams – scale & root planning. To send just this basic information described above please check here

*If you want us to release other information then please mark below.*

**INFORMATION TO BE DISCLOSED:**

Treatment plan  Radiology films/images  All billing records

Specific records/information as follows: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED:  
\_\_\_\_\_

**EXPIRATION:** This Authorization is good for one year unless dates filled in below

*From: \_\_\_\_\_ To \_\_\_\_\_*

**SIGNATURE OF PATIENT / LEGAL REP:**

DATE: \_\_\_\_\_

*If signed by a person other than the patient, complete the following:* Individual is:  parent\* legal guardian  
 legally incompetent  incapacitated deceased  next of kin / executor of deceased

**By signing, I understand that the information released per this authorization, if redisclosed by the recipient, is no longer protected by Choice One Dental.**