Dr. Bart A Samuelson, P.C.

Authorization to Release Dental Records

Patient Information:

_____
Full Name

_____
Street Address

_____
City, State, Zip

___/___/____ _____
Date of Birth **Phone Number**

Send Records To:

_____
Self or Dentist, Physician or Agency

_____
Street or Email Address

_____
City, State, Zip

_____ _____
Phone Number **Fax**

Information To Be Disclosed:

Exam and Treatment Noted
Radiographs (X-rays)
Treatment Plan
Other (Specify)_____

Purpose(s) For Disclosing Information:

Continuation of Care/Consultation
Attorney Inquiry/Legal Matter
Insurance Claim/Application
Other (Specify)_____

I understand that all information, I hereby authorize to be obtained will be held strictly confidential and cannot be released without my written consent. I understand this authorization will remain in effect until revoked by me in writing.
I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken, which was based on my consent, I may withdraw this consent at any time by submitting my request in writing.

_____
Print Name (Patient or Legal Guardian)

_____ ____/_____/____
Signature (Patient or Legal Guardian) **Date**

_____ ____/_____/____
Signature of Witness **Date**

AUTHORIZATION SIGNED BY A LEAGAL REPRESENTATIVE MUST INCLUDE A COPY OF THE GUARDIANSHIP PAPERS OR POWER OF ATTORNEY

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