Macarena Planken DDS
& Associates
we love to see you smile

AUTHORIZATION TO RELEASE DENTAL INFORMATION

(The execution of this form does not authorize the release of information other than the terms specifically described below.)

TO:_____ PATIENT NAME:_____
FAX:_____ DATE OF BIRTH: _____
SOCIAL SECURITY NUMBER:_____

RELEASE
TO:_____
I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency or individual named on this request.

INFORMATION REQUESTED:_____
Copy of complete dental chart_____
_____Copy of dental x-rays (Please Note: X-rays will only be provided within the last year of this documents date)

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:
_____Transfer of Records _____Second Opinion
Other, please explain_____
AUTHORIZATION:
I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken to comply with it. With my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event: on_____(date supplied by patient; or_____ if revoked in writing by patient; or_____180 days from the date hereof; or under the following conditions:_____.

_____
Patient Name (Print)

_____
Person authorized to sign for patient
State how authorized

_____ _____

Signature Date