



**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