Carmel Pediatric Dentistry

12188A N. Meridian Street
Carmel, IN 46032
P: (317) 846-3496 F: (317) 846-4497
www.CarmelPediatricDentistry.com

Authorization to Release Dental Records

PATIENT INFORMATION:

____
Full Name

____
Street Address

____
City, State, Zip Code

____/____/______
Date of Birth

______-______-_________
Phone

SEND RECORDS TO:

____
Self or Name of Dentists, Physician, Agency, Etc.

____
Street Address

____
City, State, Zip Code

______-______-_________
Phone

______-______-________
Fax

☐ Send via e-mail:____

INFORMATION TO BE DISCLOSED:

☐ Exam & Treatment Notes Date:__________
☐ Radiographs (X-rays) Date:__________
☐ Treatment Plan Date:__________
☐ 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 that 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/Guardian): ____

Signature (Patient/Guardian): ____ Date:______________

AUTHORIZATIONS SIGNED BY A LEGAL REPRESENTATIVE MUST INCLUDE A COPY OF THE GUARDIANSHIP PAPERS OR A POWER OF ATTORNEY.

FOR OFFICE USE ONLY:

Released by (print name):____

Signature: ____ Date:_______________

Records Released:____