CAMPBELL DENTAL GROUP

AUTHORIZATION TO DISCLOSE DENTAL HEALTH INFORMATION

I, the undersigned, authorize Campbell Dental Group to disclose the information described below to the recipient(s) described below. I understand and agree to the statements and information contained in this authorization.

PATIENT INFORMATION

Patient Full Name: _____ DOB: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Other Names During Treatment: _____

RELEASE INFORMATION

Please complete this section and check mark next to the appropriate to/from box for the request to be processed:

☐ Release Information to ☐ Request Information From

Name/Facility: _____ Attention: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Purpose of Request _____

INFORMATION TO BE RELEASED

Please provide information in my dental health records for dates: From: _____ To: _____

Place a check mark next to the requested records:

☐ Complete dental chart ☐ Dental Radiographs Other: _____

AUTHORIZATION TO RELEASE PROTECTED INFORMATION

Required - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Place a check mark next to the requested records:

☐ Complete dental chart ☐ Dental Radiographs Other: _____

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge.

Patient/Guardian Name _____ Date _____

Patient/Guardian Signature _____ Relationship _____

If a personal representative executes this authorization, then the authorization must contain a description of the representative's authority to act for the individual, e.g., "parent" or "guardian ad litem"

Campbell Dental Group
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