

**Englewood Dental Center**

**AUTHORIZATION TO RELEASE DENTAL INFORMATION**

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

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*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. I understand that the information to be released includes information regarding the following condition(s):*

Drug Abuse, if any  
 Sickle Cell Anemia, if any

Alcoholism or alcohol abuse, if any  
 Psychological or psychiatric conditions

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**INFORMATION REQUESTED:**

**DATES COVERED:**

Copy of complete dental chart

All treatment rendered in this office by this doctor

Copy of dental x-rays

\*Limited to treatment dates & for conditions described below:

Other (e.g. models-describe) \_\_\_\_\_

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**PROPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:**

Transfer of records  
 Other \_\_\_\_\_

Second opinion

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**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. Without 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:*

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**OTHER CONDITIONS:** *A copy of this Authorization or my signature thereon:   x   may, \_\_\_\_\_ may not be used with the same effectiveness as an original.*

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**SEND TO:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EMAIL TO:** \_\_\_\_\_

**PATIENT NAME (PRINT):** \_\_\_\_\_

**PERSON AUTHORIZED TO SIGN FOR PATIENT:** \_\_\_\_\_

**DATE:** \_\_\_\_\_ **PATIENT SIGNATURE:** \_\_\_\_\_