

Authorization to Release Health Care Information

(There is a minimum \$25 charge to duplicate records not sent directly to another dental office.)

Patient's name: _____ DOB: _____

SSN: _____ Previous Name: _____

Reason for Records Request:

- | | |
|--|---|
| <input type="checkbox"/> Moving to: _____ | <input type="checkbox"/> Referred to specialist |
| <input type="checkbox"/> New dentist closer to home | <input type="checkbox"/> Change of insurance |
| <input type="checkbox"/> Second opinion | <input type="checkbox"/> Cost of treatment |
| <input type="checkbox"/> Dissatisfied with service (please explain): _____ | |
| <input type="checkbox"/> Other: _____ | |

Comments: _____

We appreciate all comments and/or suggestions for improvement that you may have for us.

I request and authorize Wendel Family Dental Centre to release health care information of the patient named above to:

Please check one of the following:

- Name: _____
- Address: _____
- City: _____ State: _____ Zip: _____
- Phone: _____

- Patient will pick-up at our office

This request and authorization applies to (please check one of the following):

- Current X-rays only
- Healthcare information relating to the following treatment, condition, or dates of treatment: _____

I understand that my express consent is required to release any healthcare information.

Signature of patient or patient's authorized representative

Date

Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)