Arden Premier Dentistry

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Authorization to Release Records

I ________________________________hereby request ______________________________________
(Patient) (D.O.B) (Doctor)

to release my dental records to_________________________________.

Please forward: *preferably by email*

____Most recent Radiographs

____ Summary of treatment performed and pending treatment (email or fax)

____ ________________
Signature of Patient or Personal Representative Date

____ ________________
Print Name of Patient or Personal Representative Date

Patient Rights:

- I have the right to revoke this authorization at any time
- I may inspect or copy the protected health information to be disclosed as described in the document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.