# AUTHORIZATION TO RELEASE DENTAL INFORMATION

**Please complete the form and return to our office at admin@highlinefamilydentistry.com**

**Patient Name:** _____ **Date of Birth:** _____

**Release From:**
Highline Family Dentistry
Dr. Amy L Becker, DDS
2 W. Dry Creek Circle, Ste 125
Littleton, CO 80120
P: 303-794-6800
F: 303-794-1148
email: admin@highlinefamilydentistry.com

**Send Records to:**

_____
Doctor's Name

_____
Office Phone Number

_____
Office Email Address

## Information Requested:

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):

____ Copy of Complete Dental Chart  __X__ Copy of Recent Dental X-Rays

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

__X__ Transfer of Records  ____ Second Opinion

**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 content will automatically expire upon satisfaction of the need for disclosure.

_____ _____ _____
Print Patient Name  Patient Signature  Date

_____ _____
Person Authorized to Sign for Patient  Relationship to Patient