AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

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

Send Records to:
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

Request Records From:
_____
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