Fairmount Dental Center

A Uniquely Caring Environment

AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

TO: _____

PATIENT NAME: _____ **DOB:** _____

I request and authorize the above named doctor or healthcare 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):

INFORMATION REQUESTED:

___ Copy of complete Dental Chart
___ Copy of complete Dental X-Rays
___ Other (e.g. models – describe)

Treatment Dates:

*Limited to treatment dates and for conditions described below:
_____

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:

__ Transfer of records __ Second Opinion __ Other; please specify: _____

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. With 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: _____*

OTHER CONDITIONS: A copy of this authorization or my signature thereon ___ may, or ___ may not be used with the same effectiveness as the original.

_____
Patient Name (please print)

_____ _____
Person authorized to sign for patient State how authorized

_____ _____
Signature Date

Fairmount Dental Center LLC
1524 Commercial St SE Salem OR 97302
Phone: 503-362-8364 • Fax: 503-378-0853

Please send to Fairmountdentalcenter@gmail.com