CONIFER DENTAL GROUP
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AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

Patient Name: ______________________________________ DOB ____________

Release to: ______________________________________

____

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):

_____ Drug Abuse, if any   _____ Alcoholism or alcohol abuse, if any
_____ Sickle Cell Anemia, if any   _____ Psychological or psychiatric conditions, if any

INFORMATION REQUESTED:

____ Copy of complete dental chart
($12.50 minimum fee based on # of pages)

____ Copy of dental x-rays

____ Other (e.g. models- describe)

DATES COVERED:

____ All treatment rendered in this office

____ *Limited to treatment dates & for conditions described below:

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

____ Transfer of Records   **____ Second Opinion**
____ Other   Claim evaluation

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 consent will automatically expire upon satisfaction of the need for disclosure, but in any event: on ______(date supplied by patient); or X revoked in writing by patient; or ____180 days from the date hereof;______under the following conditions:*

OTHER CONDITIONS: *A copy of this authorization or my signature thereon: X may____may not be used with the same effectiveness as the original.*

DATE __________ PATIENT SIGNATURE ______________________________

PERSON AUTHORIZED TO SIGN FOR PATIENT: ________________________________

STATE HOW AUTHORIZED: ________________________