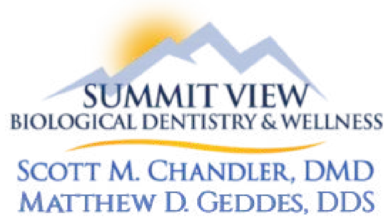
Records Release Form



Records Release

Patients Date of Birth *

__/__/____

Patients First Name *

Patients Last Name *

To Disclose To:

☐ Self ☐ Dental Provider ☐ Other *

Delivery Options:

☐ Mail ☐ Email ☐ Fax ☐ Pick Up *

Only information from the past five (5) years will be disclosed. Unless dates filled in below.

From: __/__/____

To: __/__/____

When transferring information to another dental office we only send current x-rays (bitewing x-rays. full mouth x-rays & panorex) within ti.he last 5 yrs and treatment dates for prophy's (cleanings) - exams - scale & root planning.

☐ Please check here to send just this basic information described above.

If you want us to release other information then please mark below.

Information to be Disclosed:

☐ Treatment Plan ☐ Radiology Films / Images ☐ All Billing Records

Specific records/information as follows:

I do not want the following information to be disclosed:

EXPIRATION: This Authorization is good for one year unless dates filled in below

From: __/__/____

To: __/__/____

By signing, I understand that the information released per this authorization, if re-disclosed by the recipient, is no longer protected by this Dental Office

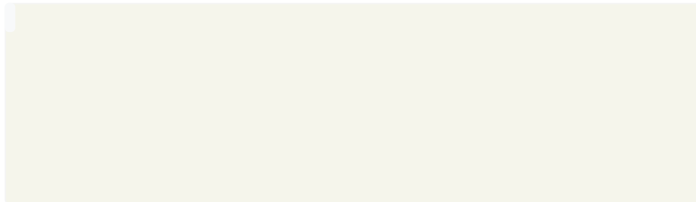
Patients First Name *

Patients Last Name *

Who is individual signing? *

○ Patient ○ Someone Else

Signature *



Today's Date

10/08/2024