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## RECORDS RELEASE FORM

PATIENT INFORMATION:

NAME OF PATIENT \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

CURRENT ADDRESS \_\_\_\_\_

CURRENT TELEPHONE \_\_\_\_\_

INFORMATION RELEASED FROM: \_\_\_\_\_

INFORMATION RELEASED TO: \_\_\_\_\_

INFORMATION TO BE FORWARDED TO HEALTH CARE PROVIDER:

PANORAMIC X-RAY \_\_\_\_\_ BITEWING X-RAYS \_\_\_\_\_ FMX \_\_\_\_\_

PROGRESS NOTES \_\_\_\_\_ OTHER: \_\_\_\_\_

THIS AUTHORIZATION SHALL BE IN EFFECT UNTIL THE INFORMATION HAS BEEN FORWARDED AS REQUESTED.

I UNDERSTAND THAT MY TREATMENT WILL NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION, AND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION BUT THAT WITHOUT MY SIGNATURE ON THIS AUTHORIZATION THE ABOVE LISTED OFFICE IS NOT ALLOWED BY HIPAA LAW TO RELEASE MY RECORDS UNLESS THEY ARE BEING RELEASED FOR INSURANCE PURPOSES OR FOR REFERRAL PURPOSES (AS UNDERLINED IN MY SIGNED HIPAA RELEASE FORM IN MY CHART). I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION (IN WRITING), AND THAT A REVOCATION IS NOT EFFECTIVE IF THE INFORMATION HAS ALREADY BEEN FORWARDED.

\_\_\_\_\_  
SIGNATURE OF PATIENT, OR PARENT AND/OR GUARDIAN

\_\_\_\_\_  
DATE