AUTHORIZATION TO RELEASE DENTAL INFORMATION

TO:_____ PATIENT NAME:_____

FAX: _____ DOB: _____SSN:_____

RELEASE TO:_____

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):

INFORMATION REQUESTED:

_____Copy of complete dental chart
_____Copy of dental x-rays
_____All treatment rendered
_____Others (e.g. models—describe)

DATES COVERED:

*Limited to treatment dates and for condition described below:

_____

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:

_____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.*

_____
Patient Name (Print)

_____
Patient Name (Signature) and Date

Mark A. Cruz, DDS

32241 Crown Valley Pkwy., #200

Monarch Beach, CA 92629

PH (949) 661-1006 Fax (949) 661-9454