AUTHORIZATION TO RELEASE MEDICAL RECORDS

Receive Records From:

_____

_____

_____

Release Records To:

Willden Family Dental
816 South First Street
Montrose, CO 81401
Phone: (970) 249-2533
Fax: (970) 252-8234
office@willdendental.com

Purpose/Need for records:

☐ Transfer of records ☐ Second opinion ☐ Other: _____

Information requested:

☐ Copy of complete dental chart

☐ Copy of dental x-rays

☐ Copy of perio exam

☐ Other (e.g. models) _____

I request and authorize the above-named doctor or health care facility to release the information specified to Willden Family Dental and Staff.

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 the Authorization to Release Medication Records 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.

Patient Name **D.O.B.**

_____ _____

Signature: _____ Date: _____