AUTHORIZATION TO RELEASE DENTAL INFORMATION

(THE EXECUTION OF THIS FORM DOES NOT AUTHORIZE THE RELEASE OF INFORMATION OTHER THAN THE TERMS SPECIFICALLY DESCRIBED BELOW.)

NAME OF PATIENT: ____DOB: _______________

ADDITIONAL FAMILY MEMBERS REQUESTING:
NAME: ____DOB: ______________
NAME: ____DOB: ______________
NAME: ____DOB: ______________
NAME: ____DOB: ______________
____

PREVIOUS DENTIST: ____
PHONE#: _________________________________ FAX#: ______________________________
DENTAL CLINIC: ____
LOCATION & STATE: ____

INFORMATION REQUESTING:

☐ COPY OF COMPLETE DENTAL CHART ☐ COPIES OF *ALL* DENTAL X-RAYS

☐ ALL TREATMENT RENDERED ☐ COPIES OF CURRENT DENTAL X-RAYS

☐ OTHER SPECIFICATIONS (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 ☐ OTHER: _________________________

* I, (print name) ____, hereby give you permission to release any, and all, of my Dental Records (including my dependents listed) to Bliss Family Dental in Prior Lake, MN.

PREFERRED METHOD, EMAIL PATIENT(S) RECORDS TO: **info@blissfamilydental.com**

Or Mail to Us at Bliss Family Dental, 4792 Dakota Street SE, Prior Lake, MN, 55372

PATIENT/GUARDIAN SIGNATURE: ____________________________________DATE: ____________

PHONE 952-447-3777
FAX 952-447-2877
EMAIL info@blissfamilydental.com
WEBSITE www.blissfamilydental.com