CONSENT FOR RELEASE OF PATIENT INFORMATION

I hereby authorize _____ to release information from
(Practice or Dentist Name)

the dental record(s) of: _____
(Print name of patient)

This release may include information regarding communicable diseases such as Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS), Psychiatry, Drug, and/or Alcohol Abuse, unless specifically requested to be omitted.

Covering the period(s) of dental treatment: _____
Birth Date: _____ Social Security #: _____
Purpose of Release: _____

INFORMATION TO BE RELEASED (check one):

_____Copy of progress notes only.

_____Copy of radiographs only.

_____Copy of complete dental record (patient history, exam, diagnoses, treatment plan, progress notes, and radiographs).

This information is to be released to: **Liberty Park Dental**

1508 NE 96th, Suite A
Liberty, MO 64068
(816) 415-8080

(816) 415-8083 Fax

AUTHORIZATION:

I understand this authorization is valid for a period of ninety (90) days or until expressly revoked by me. I understand that I may withdraw this authorization by submitting a written, dated request, and that such revocation does not affect action that already has been taken based on this authorization.

Signed: _____ _____
(Patient, Parent, or Legal Representative) (Date)

_____
(Relationship to patient)