

# 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)