Permission to release records from Eastview Family Dentistry

Patient Name:___________________________________ Date of Birth: ____________________

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I hereby authorize Eastview Family Dentistry to release my dental records to:

Name:____

Address: ____

Phone: _____________________________ Fax: _________________________________

Email address (PRINT VERY CLEARLY):____

I understand that I am signing this authorization freely; that I may revoke this authorization at any time by providing written notice to the practice: that I may not revoke this authorization if the practice has already taken action utilizing this authorization; that the information disclosed in this authorization may be subject to redisclosure by the practice and no longer protected by federal law; and I understand the intent and use of this authorization.

By signing this document, I understand that all future appointments at Eastview Family Dentistry will be canceled for all patients listed above. Any warranties that have been given for restorations will be voided.

If the request is by a Patient:

Signature of Patient: ________________________________ Date: ________________

If the request is by a patient's personal representative:

Print the Name of the Personal Representative:______________________________________

Relationship to the Patient(s):____

I certify that I have the legal authority under federal and state laws to make this request on behalf of the patient identified above.

Signature of Personal Representative:_____________________________________Date:______________

For Office Use:
Records released: Date: _______________ Format:_______________ Initials:___________