DENTAL ARTS
OF PALM HARBOR

Medical Records Release

(Name of Patient) _____ (Birthdate) _____

Authorizes:

(Name of Physician) _____

(Name of Dental Office) _____

(Email Address) _____

(Phone #) _____

Release of Records to:

(Name of Physician) _____

(Name of Dental Office) _____

(Email Address) _____

(Phone #) _____

I understand that this authorization shall be valid for one (1) year unless otherwise stated below or revoked through written notice to Medical Records.

(Alternate date if not (1) year) _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged.

Signature of Patient/Parent: _____ Date: _____

(If signed by person other than patient, state relationship and authorization to do so)