DR. ROBERT W. PRICE, D.M.D.
GENERAL DENTISTRY

AUTHORIZATION TO RELEASE DENTAL INFORMATION

(The execution of this form does not authorize the release of information other than the terms specifically described below.)

PATIENT NAME (s): _____ **DOB**: _____

_____ _____

_____ _____

_____ _____

_____ _____

RELEASE TO: Dr. Robert W. Price, DMD **FAX NUMBER**: (309)833.4554 **PHONE NUMBER**: (309)255.9750

I request and authorize the release the information specified below to Dr. Robert W. Price, DMD. I understand that the information to be released includes information regarding the following condition(s):

INFORMATION REQUESTED:

_____Copy of complete dental chart including progress notes
_____Copy of dental x-rays
_____Copy of insurance information (if applicable)
_____All treatment rendered _____
_____Others (e.g. models, impressions, etc.)

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:

_____Transfer of Records _____Second Opinion

_____Other, please explain: _____

AUTHORIZATION:

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken to comply with it.

OTHER CONDITIONS:

A COPY of this Authorization: _____ MAY or _____ MAY NOT be used with the same effectiveness as an original.

PATIENT NAME (Please Print): _____ **DATE:** _____

SIGNATURE OF PATIENT or GUARDIAN: _____