AUTHORIZATION TO RELEASE DENTAL INFORMATION

THE EXECUTION OF THIS FORM DOES NOT AUTHORIZE THE RELEASE OF INFORMANTION OTHER THAN THAT SPECIFICALLY DESCRIBED BELOW

FORMER DENTAL OFFICE INFORMATION:

DR'S NAME/NAME OF PRACTICE: _____

ADDRESS: _____

PHONE NUMBER: _____

FAX NUMBER: _____

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____

PLEASE RELEASE TO:

CHRIS J DUMAS DDS, PC
COMPREHENSIVE AND COSMETIC DENTISTRY
6900 E. BELLEVIEW AVE. #203
GREENWOOD VILLAGE, CO 80111
EMAIL: info@drdumas.com

INFORMATION REQUESTED:

COPY OF DENTAL XRAYS

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

TRANSFER OF RECORDS

AUTHORIZTION: 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. WITHOUT MY EXRESS REVOCATION, THIS CONSENT WILL AUTOMATICALLY EXPIRE UPON SATISFACTION OF THE NEED FOR DISCLOSURE.

PATIENT NAME: _____ (PLEASE PRINT)

PATIENT SIGNATURE: _____

DATE: _____