Foothills Family Dental
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Fort Collins, Colorado 80524
970-482-6841
Fax 970-484-5555
fcsmiles@gmail.com

AUTHORIZATION TO RELEASE DENTAL INFORMATION FROM PREVIOUS DENTAL OFFICE

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

Patient name:_____

Date of birth:_____

Release to:_____ Release from:_____

I request and authorize the above named doctor or health care provider to release the information specified below to the organization, agency, or individual named on this request.

INFORMATION REQUESTED: DATES COVERED:

____Copy of complete dental chart ___All treatment rendered in this office

____Copy of dental x-rays __Limited to treatment dates for or of

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

____Transfer of records _____Second Opinion
____Other Claim Evaluation

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. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event: on_____(date supplied by patient); or___X__revoked in writing by patient; or _____180 days from the date hereof; or_____under the following conditions:

OTHER CONDITIONS: A copy of this authorization or my signature thereon:_X_ may, ____may not be used with the same effectiveness as an original.

PATIENT NAME:_____ DATE:_____

PATIENT SIGNATURE:_____

PERSON AUTHORIZED TO SIGN FOR PATIENT:_____
STATE HOW AUTHORIZED:

Reason for request:_____

What can we do to help improve our office? _____