Authorization for use/disclosure of medical and dental information

Authorization for Use/Disclosure of Information
I voluntarily consent to authorize my medical AND dental providers to use or disclose my health information to the recipient that I have identified below:

Recipient

Purpose or need for which information is to be used:

The patient's dental records are required for comprehensive evaluation and ongoing care. This request is not related to transferring care, but rather is intended to help us provide the most appropriate and effective dental treatment for the patient.

MEDICAL RELEASE
Information requested

I authorize the release of All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition, and any treatment I received.

DENTAL RELEASE
Information requested

I authorize the release of All of my dental information that the provider has in his or her possession:

Copy of dental x-rays
Copy of Periodontal Chart
All treatment rendered
Other: Statement of opinion of patient’s dental fitness for an oral airway appliance

Authorization

I hereby authorize my healthcare provider, its agents, and its employees to release my protected health information described above. I certify that this request has been made

voluntarily and the information provided is accurate to the best of my knowledge. I understand that I can revoke this authorization at any time, except for actions already taken to comply with it.