AUTHORIZATION FOR RELEASE OF DENTAL/MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Previous Name (if applicable): _____

I AUTHORIZE THE RELEASE OF MEDICAL/DENTAL RECORDS FROM:

Doctor Name: _____

Address: _____

City/State/Zip: _____ Phone: _____

PLEASE EMAIL OR SEND RECORDS TO:

Boise Integrative Dentistry
7878 Ustick Road, Suite 101
Boise, ID 83704
Phone: 208.376.2920 Fax: 208.376.8509 **Email: info@boise-dentist.com**

- I give permission to release my dental records including: X-rays, clinical records, chart notes and health information.
- This medical information may be used by the person I authorize to receive this information for dental treatment or consultation, billing or claims payment, or other purposes as I may direct.
- I understand that I have the right to revoke this authorization, in writing, at any time.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Patient or Legal Guardian Signature **Date**