AUTHORIZATION TO RELEASE DENTAL INFORMATION

RELEASE TO: Buena Vista Dental Care
Ryan A. Mueller, D.M.D
PO Box 4830
Buena Vista, CO 81211
719-395-2240 (email xrays to: buenavistadentalcare@gmail.com)

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

TO:	**PATIENT INFORMATION**	**PATIENT INFORMATION**
_____	_____	_____
	Name	Name
_____	_____	_____
	Date of Birth	Date of Birth
_____	_____	_____
_____		

Phone & Fax _____

_____

***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. I understand that the information to be released includes information regarding the following condition(s)*:**

INFORMATION REQUESTED:

_X_ Copy of complete dental chart

_X_ Copy of dental x-rays

____ Other (e.g. models – describe) _____

DATES COVERED:

_X_ All treatment rendered in this office or by this doctor.

____ *Limited to treatment dates & for conditions described below:

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

_____ Transfer of records _____ Second Opinion

_____ Other _____

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 even: on _____ (date supplied by patient); or _____ if 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 (Please print)

_____
PATIENT SIGNATURE DATE

_____
PATIENT NAME (Please print)

_____
PATIENT SIGNATURE DATE

PERSON AUTHORIZED TO SIGN FOR PATIENT:

_____

State How Authorized: _____