AUTHORIZATION FOR RELEASE OF INFORMATION

Each section must be completed.

I. I, _____ , hereby request the disclosure of information from my record.
(Patient name)

II. The information is to be released from:

Name of Facility _____

Address _____

City/State _____

and is to be provided to:

Arizona Dental Medicine, PLLC
6596 North Oracle Road
Tucson, AZ 85704

III. The purpose or need for this disclosure is:

_____

_____

IV. The information to be released is for my:

☐ Dental Record to include _____

V. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in the reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of signature. I further understand that a fee may be associated with the release of these records.

Signature of Patient: _____ _____
(Date)

Signature of Parent,
Guardian or Authorized
Representative *(if necessary)* _____ _____
(Date)

VI. PATIENT'S IDENTIFICATION:

NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____