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:

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

and is to be provided to: Self or Other Provider's Office

Name of Facility _____

Address _____

City/State _____

III. The purpose or need for this disclosure is:

_____

_____

IV. The information to be released is for my:

☐ Dental Record which includes_____

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 If this authorization has not been revoked, it will terminate one year from the date of signature.

Signature of Patient: _____ _____
(Date)

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

VI. PATIENT'S IDENTIFICATION:

NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____

** ALL RECORDS ARE SUBJECT TO A $25.00 DUPLICATING FEE **