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AUTHORIZATION TO RELEASE PATIENT RECORDS

Date: _____

Patient Name: _____ DOB: _____

I, _____ (authorized person) hereby authorize and request that you release legible copies of all records (this includes but is not limited to radiographs, treatment and progress notes) concerning findings and treatment of _____ that you have in your possession to:

TRANSFERING TO: _____
_____
_____

REASON/TRANSFER: _____
_____
_____

ENCLOSED (most recent available):

BITEWING X-RAYS:	_____	DATE: _____
FMX:	_____	DATE: _____
PROPHY:	_____	DATE: _____

I hereby release the above referenced dentist from any liability related to disclosure of confidential or privileged information. I understand and agree that only the copies of those records and radiographs contained in your files will be released and the originals will remain property of the dentist.

_____ WITNESS: _____
(SIGNATURE OF PATIENT OR AUTHORIZED INDIVIDUAL)

_____ DATE: _____

According to A.R.S. §32-1264 on a patient's request the dentist, dental hygienist or denturist shall transfer quality copies of the patient's records to another licensee or certificate holder or the patient may receive a copy. You may be charged for the records released. Please note- release of the records means all records, not simply radiographs or a summary of the records.