Authorization for Release of Dental Information

Patients Name:
DOB:
Address:
Phone:

PROVIDER: Southern Heights Dental Group
1575 20th Street N.W., Suite 102
Faribault, MN 55021-2932
PHONE: (507)334-6433
FAX: 507-334-0044
EMAIL: info@southernheightsdental.com

REQUESTER:

__ Patient
__ Dental Clinic
__ Hospital
__ Other: _____ (short description)

RECORDS TO BE SENT:

Name: _____
Address: _____
City/State/Zip: _____
Phone:_____ FAX:_____
Email:_____

INFORMATION REQUESTED:

__ Dental Records
__ X-Rays
__ Pre-Estimate

SPECIFIC DATES OF IMAGES: _____
_____
_

PURPOSE OF RELEASE:

__ Transferred to another clinic
__ Insurance processing
__ Ligation
__ Other: _____

I give permission to the PROVIDER to release dental record information to the REQUESTER concerning the DENTAL CONDITION/INJURY described above, which was diagnosed/treated during the stated TIME PERIOD. I understand that this release will take effect on the date signed and will be in effect for one year. I understand that I can cancel this release at any time by notifying the PROVIDER in writing that my cancellation will take effect when the PROVIDER receives my written notice. I understand that my cancellation will not have any effect on information released before the PROVIDER received my written notice.I give permission to the PROVIDER to release dental record information to the REQUESTER concerning the DENTAL CONDITION / INJURY described above, which was diagnosed / treated during the stated TIME PERIOD.
* * Bill for transfer of records based on discretion of Southern Heights Dental management

_____ 10/05/2017
Signature of Patient or Guardian Today's Date

- OFFICE USE ONLY -
IF ELECTRONIC MEDIA - hand deliver this form to the Director of the IT Department for completion of electronic