## Release of Patient’s Records

The following information is for records on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient DOB: / /

Patient Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Phone Number: ( ) -

I hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to release records to Alizadeh and Schreiner Orthodontics.

Information to be released:

* Dental Records
* Patient Report(s) Prepared from this office
* Test results
* X-Rays
* Polysomnography (PSG’s)

Records are needed for:

* Coordinating Care for Oral Appliance for Obstructive Sleep Apnea
* Insurance
* Communication with your other health care providers
* Legal Purposes
* Continuing Care
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the information to be released may include history, diagnosis, and/ or treatment or therapy related to this dental office. I also understand that this authorization may be revoked by the person giving authorization by a written and dated notice, except to the extent that disclosure of information has been made prior to this revocation. I have read and understand this consent and I have signed it voluntarily and of my own free will.

Signature X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: / /

 Prohibition of disclosure: This information has been disclosed to you from records, which are confidential. You are prohibited from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.