FRANK HARMON, D.D.S.
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LAKEWOOD, COLORADO 80215
PHONE: 303-233-2906 FAX: 303-233-2671

AUTHORIZATION TO RELEASE DENTAL INFORMATION

(The execution of this form does not authorize release of information other than that specifically described below.)

PATIENT NAME: **RELEASE TO:**
ADDRESS:
DOB:

I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

* Drug abuse, if any
* Alcoholism or alcohol abuse, if any
* Sickle Cell Anemia, if any
* Psychological or psychiatric conditions, if any

INFORMATION REQUESTED:

____ Copy of complete dental chart

____ Copy of dental x-rays

____ Other (e.g. models – describe)

DATES COVERED:

____ All treatment rendered in this office or by this doctor

____ Limited to treatment dates & for conditions described below

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PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

____ Transfer of records

____ Second Opinion

____ Other

____ Claim evaluation

AUTHORIZATION: *I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event: on ______ (date supplied by patient); or __x__ revoked in writing by patient; or ____ 180 days from the date hereof; or ____ under the following conditions:*

OTHER CONDITIONS: *A copy of this Authorization or my signature thereon: __x__ may, _____ may not be used with the same effectiveness as an original.*

____
PATIENT NAME (PRINT)

PERSON AUTHORIZED TO SIGN FOR PATIENT:

____

____
PATIENT SIGNATURE

____
STATE HOW AUTHORIZED

____
DATE