ANIMAS PEDIATRIC DENTAL GROUP

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LAWRENCE E. SUAZO, D.D.S. KRISTIN MURPHY D.M.D.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT:_____ BirthDate:_____

AUTHORIZATION: I authorize: Animas Pediatric Dental Group
To release the information specified below to the following organization, individual or agency:

RELEASE TO: _____

_____
(Name/Address/Telephone #)

INFORMATION REQUESTED:

[ ] Dental X-rays [ ] Other: _____
Dates requested: _____

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

[ ] Changing Providers [ ] Worker's Compensation
[ ] Moving [ ] Legal Action
[ ] Insurance/Payor Claim [ ] Referral: _____
[ ] _____

EXPIRATION OR REVOCATION OF AUTHORIZATION: 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. I understand that this authorization will not apply to admissions or care provided after the date of my signature.

THIS AUTHORIZATION EXPIRES 6 MONTHS AFER THE DATE IT IS SIGNED.

***We only release records generated in this clinic.

_____ _____
Signature of Patient (or patient's authorized representative) Date of Signature

_____
Relationship to patient (parent, legal guardian, personal representative, etc.)

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Administrative Staff Member authorizing release: _____

Date Sent:_____ Sent by: _____