Payne & Boatner, DDS
preventive & restorative dentistry

AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

PATIENT NAME: _____ DOB: _____

FAX/E-MAIL WHERE WE ARE SENDING RECORDS: _____

RELEASE INFORMATION TO: _____

I request and authorize Payne & Boatner DDS to release the information specified below to the organization, agency, or individual named on this request. I understand that the information to be released may include information regarding medical conditions.

Information Requested:

____ Copy of complete dental chart

____ Copy of dental x-rays

____ All Treatment Rendered

____ Others (e.g. models—describe)_____

PURPOSE OR NEED FOR WHICH THE INFORMATION IS TO BE USED:

_____ Transfer of Records _____ Second Opinion

_____ Other, please explain _____

Print Patient Name: _____

Patient or Representative Signature_____ Date_____