Olympia Dental
Inclusive 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.)

TO: Dr. **PATIENT NAME**:

RELEASE TO: Olympia Dental (Dr. Martin Bourgeois)
VIA EMAIL: frontdesk@olympiadental.com

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.

INFORMATION REQUESTED:

_____Copy of complete dental chart

_____Copy of dental x-rays (last 5 years)

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:

_____Transfer of Records _____Second Opinion

_____Other, please explain_____

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.

_____
Patient Name (Print)

_____ _____
Person authorized to sign for patient State how authorized

_____
Signature Date