BRUSH DENTAL

AUTHORIZATION TO RELEASE DENTAL INFORMATION

PLEASE FILL OUT IF YOU HAVE BEEN SEEN AT ANOTHER FACILITY IN THE LAST 3 YEARS

To:	**Patient Information:**	**Please Release To:**
______________________	Name: ______________	______________________
______________________	DOB: ______________	______________________
______________________	SSN: ______________	______________________

I, ____, hereby and give my permission to

____to provide Brush Dental – Hal P.

Whitney & Terri Gonzales RDH B.S. any and all information regarding past dental care for

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[ ] Transfer of records **[ ] Second Opinion**

Such records may include medical care treatment, illness or injury, dental history, medical history, consultations, prescriptions, radiographs, models and copies of all dental records and medical records.

[ ] Please forward all radiographs, treatment plan and chart notes.

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:*

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PATIENT NAME (Print) **PATIENT/GUARDIAN SIGNATURE** **DATE**

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GUARDIAN NAME (Print**)** **RELATIONSHIP TO PATIENT** **PHONE NUMBER**

Brush Dental 412 Edison Street Brush Colorado 80723 (P) (970) 842-0220 (E) brushdenta412@gmail.com