AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

Patient: _____
DOB: _____
SSN: _____

Release to: Wynkoop Dental
1401 Wynkoop Street Suite 160
Denver, CO 80202
office@denverwynkoopdentist.com

Release From Previous Office:
Office name: _____
Office address: _____
Office phone/email: _____

I request & authorize the release of the information specified below to the organization, agency or individual on this request.

INFORMATION REQUESTED:

_____ Copy of dental records **Additional information by request.**

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

_____Transfer of Records **_____Second opinion**

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 had already been take to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for the disclosure, but in the event: (on_____) date supplied by patient); or 180 date from the date hereof; or under the following conditions:

OTHER CODITIONS: a copy of this authorization or my signature may _____may not _____be used with the same effectiveness as an original.

Patient name (please print)_____

Patient or authorized signature: _____ Date: _____

Wynkoop Dental
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