AUTHORIZATION TO RELEASE DENTAL INFORMATION

RELEASE FROM:

RELEASE TO: Dr. Troy A. Fox, D.D.S.
Evergreen Family Dentistry, P.C.
3720 Evergreen Parkway
P.O. Box 3958
Evergreen, CO 80437

PATIENT'S NAME: _____ **D.O.B**: _____

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

I request and authorize _____ to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes information regarding my general health history and dental health history.

INFORMATION REQUESTED:

____ Copy of complete dental chart
____ All treatment rendered in this office.
____ Copy of dental x-rays
____ Other

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:

____ Transfer of Records
____ Second Opinion
____ Other/Claim evaluation

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. A copy of this Authorization or my signature may be used with the same effectiveness as an original.

Signature: _____ Date: _____
(patient, or parent/guardian if minor)

Phone: 303/674-3591 Fax: 303/674-9650