Fox Dental

1293 E McAndrews Road. Medford, OR. 97504
Phone:541-772-1215 Fax: 541-772-3210

AUTHORIZATION TO RELEASE DENTAL INFORMATION

Patients Name: _____ **Date of Birth:** _____

I hereby authorize: _____
(Dental Provider's/ Facility Name)

Address:_____ **City:** _____ **State:**_____ **Zip code:**_____

TO RELEASE A COPY OF DENTAL INFORMATION TO:

Dr. Adam Fox
1293 East McAndrews Road
Medford, OR. 97504

***Please E-mail Records to*:** Nicole@dentistmedford.com **OR** info@dentistmedford.com

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I request and authorize the above names doctor or health care provider to release the information specified below to the organization, agency or individual names on this request. I understand that the information to be released includes information regarding the following condition(s):

By initialing the spaces below, I specifically authorize the release of the following dental records. If such records exist:
(MUST BE INITAILED TO BE INCLUDED)

INFORMATION REQUESTED:

___Copy of complete dental chart
___Copy of dental x-rays
___All treatment rendered
___Other (e.g. models-describe)

This information will be used on my behalf for the following purposes:

___Transfer of records
___ Second opinion
___Other, please explain_____

I have reviewed and I understand this authorization. I also understand that the information used or disclosed to this authorization may be subject to re-disclose by the recipient and no longer be protected under federal law. I herby authorize exchange of information between authorized agencies above.

Signature of patient: _____ **Date:** _____

If the patient is unable to sign, is minor under age 15, or is the guardian:

Representatives signature_____ **Date:** _____

Relationship of representative to patient: _____

Signature of Witness: _____ **Date:** _____