

**AUTHORIZATION TO RELEASE DENTAL INFORMATION**

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_____ Patient's Last Name	_____ First	_____ MI	_____ Date of Birth
_____ Any other name known by			_____ Social Security Number
_____ Patient's Mailing Address			
_____ City	_____ State	_____ Zip	_____ Phone Number

**I WANT PHC TO GET MY RECORDS FROM**

The following provider and therefore I authorize them to release records to PHC:

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\_\_\_\_\_  
Provider's Name

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\_\_\_\_\_  
Dental Facility Name or Address

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\_\_\_\_\_  
City

---

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
State

---

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Zip

**I WANT PHC TO SEND MY RECORDS TO** The

following provider and I authorize PHC to release records to:

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\_\_\_\_\_  
Provider's Name

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\_\_\_\_\_  
Dental Facility Name or Address

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\_\_\_\_\_  
City

---

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
State

---

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Zip

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\_\_\_\_\_  
Provider e-mail

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. I understand that the information to be released includes information regarding the following conditions(s):

**INFORMATION REQUESTED:**

Copy of dental x-rays

My dental records for the following dates:

Entire dental record

Include Exclude: My health information related to drug and/or alcohol abuse

Include Exclude: My health information related to HIV/AIDS

Most recent \_\_\_\_\_ years of record

Other Information (describe information in detail) \_\_\_\_\_

**PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:**

Treatment Second Opinion

To the following Family Members: \_\_\_\_\_

Other, (describe the purpose of the requested use and disclosure in detail): \_\_\_\_\_

**AUTHORIZATION:** I authorize the release of my confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. I understand that this authorization may be revoked by me at any time, provided that I do so in writing, up to the extent that the disclosure has not already been made. The revocation is effective from the time it is communicated to the health care provider. If not revoked, this authorization expires in six (6) months from the date of signature unless otherwise specified.  
(MCA 50-16-527)

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_____ Patient Name (print)	_____ Patient Signature	_____ Date
_____ Signature of Patient's Authorized Representative	_____ Relationship to Patient if Personal Representative	