Your Smile. Our Tradition.
Downtown Dental
Charlotte C. Wiedenman, DMD

# AUTHORIZATION TO RELEASE DENTAL INFORMATION

Healthcare Provider to Release Records: _____

Patient Name: _____ Phone:_____

DOB: _____ SSN:_____ Email:_____

Dental Practice to Receive Records:__Downtown Dental—Charlotte C. Wiedenman, DMD

I request and authorize the above-named doctor or health care provider to release the information specified to **Downtown Dental—Charlotte C. Wiedenman, DMD**. I understand that the information to be released includes information regarding the following condition(s):

**INFORMATION REQUESTED:** **DATES COVERED: _____**

____ Copy of complete dental chart
____ Copy of most recent dental radiographs
____ Most recent 12 months of treatment notes
____ Others (e.g. models –describe)

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

___ Transfer of Records _____ Second Opinion

_____ Other, please explain _____

**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.

_____
Patient Name (Print)

_____ _____
Signature Date

_____ _____
Person authorized to sign for patient Relationship

_____ _____
Signature Date