CENTRAL PARK DENTISTRY

REQUEST FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize the release of dental records and copies of current radiographs for the individual listed below:

NAME:________________________________ **DATE OF BIRTH:**________________

These records are to be transferred to:

SEAT DATES OF PREVIOUS CROWNS: ____________________________________

SRP HISTORY: ____

CENTRAL PARK DENTISTRY
23 NORTH FEDERAL AVE
MASON CITY, IA 50401

PHONE: 641-423-4225
FAX: 641-423-1697

EMAIL: cpd@centralparkdentistry.com

____ _______________________

Signature of Patient or Legal Guardian **Date**
(Patients over 18 must sign own release)

This authorization will automatically expire one year from date of signature or until__________________.
This consent may be revoked at any time by notifying the above named provider of information. Any release of information made prior to my revocation in compliance with this authorization shall not constitute any breach of my rights to confidentially. Disclosed information may be reviewed by contacting the provider information.

RESTRICTIONS:
This authorization is being given with the understanding that the receiver may not further use the information unless another authorization is obtained from me or unless such use of discloser is specifically required or permitted by law.