Wildflower Dental

DENTAL RECORDS RELEASE FORM

PATIENT INFORMATION:

Name: ____ Date of Birth: ____________________

AUTHORIZES:

Wildflower Dental
18818 N. 99th Ave. – Sun City – AZ – 85373

TO DISCLOSE TO: ____Self ____Dental Provider ____Other:______________________________________

DELIVERY METHOD: ___Mail ____Email ____Fax ____Pick up *(please fill in below)*

I hereby authorize ____ to pick up my records. *(Photo ID required.)*

Send to:____Phone:_________________________

Delivery Method Info:____

Physical Address, Email address or Fax # based on delivery method selected

INFORMATION TO BE DISCLOSED: Only information from the past five (5) years will be disclosed.

When transferring information to another dental office we only send current x-rays (bitewing x-rays, full mouth x-rays & panorex) within the last 5 yrs and a copy of your ledger showing the services provided in our office.
Check here:_____To send just this basic information described above.

To request the release of additional information, please mark your selection below. Please note, some information may require a fee for duplication and can take up to 15 days from the receipt of the written request.

____Treatment plan ____CT Scan ($99 fee) ____Billing/Payment Info ____Other:______________________

I DO NOT want the following information disclosed:____

I understand that this authorization is only valid for 1 year from the date of the signature. I further understand that any information disclosed by the recipient is no longer protected by Wildflower Dental.

Print:___________________________________Sign:____________________________________Date:___________

If signed by a person other than the patient, complete the following:

___Parent/Legal guardian ___Power of Attorney ___Executor of Estate ___Next of Kin (deceased patients only)