AUTHORIZATION TO RELEASE DENTAL INFORMATION

(The execution of this form does not authorize the release of information other than that specifically described below)

TO: Patient Name: Release To:

D.O.B. Emily R. Batson DDS, PC

SSN 1580 E. Cheyenne Mtn. Blvd Ste. C Colorado Springs, CO 80906

Fax: 719-576-3070

Email: batsonfrontdesk@gmail.com

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

\_\_\_\_\_\_ Copy of dental records \_\_\_\_\_\_ TRANSFER OF RECORDS

\_\_\_\_\_\_Copy of Dental x-rays \_\_\_\_\_\_ SECOND OPINION

\_\_\_\_\_\_ Other (models, etc.)

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. Without my express revocation this consent will automatically expire upon satisfaction of the need for disclosure, but in any event:\_\_\_\_\_\_\_\_\_ (date given by patient); or \_\_\_\_\_ if revoked in writing by patient; or \_\_\_\_\_\_ 180 days from the date hereof; or\_\_\_\_\_\_\_\_\_ under the following conditions:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other conditions: A copy of this authorization or my signature thereon: \_\_\_\_\_ may, \_\_\_\_\_may not be used with the same effectiveness as an original.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT NAME (PRINT) PATIENT SIGNATURE DATE