DR. EMILY BATSON
DENTISTRY & PROSTHODONTICS

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:

D.O.B.:

Release To: **Dr. Emily Batson**

1580 East Cheyenne Mountain Blvd. Suite 140
Colorado Springs, CO 80906
Phone: 719-576-4247
Fax: 719-576-3070

INFORMATION REQUESTED:

____ Copy of dental records

____ Copy of dental x-rays

____ Other (Models, etc.)

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:

____ Transfer of records

____ Second opinion

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**

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