DESERT BLOOM DENTISTRY

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

SECTION A: PATIENT GIVING CONSENT

Date: _____

Name: _____ DOB: _____

Address: _____

Phone: _____ Email: _____

Patient Number: _____

SECTION B: AUTHORIZATION TO RELEASE INFORMATION

❒ **I authorize Desert Bloom Dentistry to RELEASE medical records/information to:**

Send information via: ❒ Mail ❒ Fax ❒ Email

Name of Facility, Person or Provider _____

Address _____ City, State, Zip _____

Phone _____ Fax _____

Email: _____

Authorization valid for: ❒ This request only ❒ One year from date of request

❒ **I authorize Desert Bloom Dentistry to OBTAIN medical records/information from:**

Name of Facility, Person or Provider _____

Address _____ City, State, Zip _____

Phone _____ Fax _____

Authorization valid for: ❒ This request only ❒ One year from date of request

Type of records requested:

❒ Treatment Summary (includes history, physical, lab, xray, pathology & operative reports)

❒ All Records ❒ Progress Notes ❒ Imaging ❒ Lab/Pathology

Date(s) needed: _____

SECTION C: SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare information.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____