bold dental

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Full Name: _____

Patient's Date of Birth: _____ SS#: _____

I HEREBY CONSENT AND AUTHORIZE BOLD DENTAL TO:

☐ OBTAIN FROM: ☐ RELEASE TO:

Name / Business: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

SPECIFIC RECORDS TO BE RELEASED OR OBTAINED BY CHECKING BELOW:

☐ All medical records ☐ Operative reports

☐ Lab report (s) ☐ Pathology report (s)

☐ X-Rays ☐ Other (Please specify) _____

I request records for the following purpose: _____

I further release the physician and staff of Bold Dental from any liability arising from the release of this information to the above stated facility of person, provided that the said release is performed in accordance with the applicable law.

_____ _____

SIGNATURE OF PATIENT/GUARDIAN RELATIONSHIP TO PATIENT

_____ _____

SIGNATURE OF WITNESS DATE

A PHOTOSTATIC COPY OF THIS REQUEST IS AS VALID AS THE ORIGINAL. SIGNATURE ON FILE WILL BE CONSIDERED VALID INDEFINITELY. THE FEDERAL RULES RESTRICT ANY USE OF INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE PATIENT. (Revised 11.1.12)