WATERVIEW DENTAL GROUP

DENTAL RECORDS RELEASE FORM

Patient Name: ____ **Date of Birth:** _____/_____/_____

AUTHORIZES: ____

Name of Health Care Provider / Plan / Other/ Myself

TO DISCLOSE TO: ☐Self ☐ Dental Provider ☐ Other: ________________

Delivery options: ☐ Mail ☐ Email ☐ Fax ☐Pick-Up *(please fill in below)*

Pick-Up: I hereby authorize ____________________________ to pick up my records. (Photo ID required.)

Send to:

Waterview Dental Group
553 Portland-Cobalt Rd Unit 1 Portland, CT 06480
Phone #: (860) 342-4141 Fax #: (860) 342-1284
Email: waterviewdental@gmail.com

Only information from the past five (5) years will be disclosed. Unless dates filled in below.
From: _____/_____/______ *To:* _____/_____/_____

When transferring information to our dental office please send current x-rays (bitewing x-rays, full mouth x-rays & panorex) within the last 5 yrs and treatment dates for prophy's (cleanings) – exams – scale & root planning.

To send just this basic information described above please check here ☐

If you want to release other information then please mark below:

INFORMATION TO BE DISCLOSED:

Treatment plan ☐ *Radiology films/images* ☐ *All billing records* ☐

Specific records/information as follows: ____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED:

EXPIRATION: This Authorization is good for one year unless dates filled in below:
From: ______/______/______ *To:* ______/______/______

SIGNATURE OF PATIENT / LEGAL REP: ______________________________ **DATE:** _____/_____/_____

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

Individual is: ☐ Parent/legal guardian ☐ Legally incompetent ☐ Incapacitated/Deceased ☐ Next of kin/Executor of deceased