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AUTHORIZATION TO RELEASE HEALTH INFORMATION

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Patient name, address & date of birth

I hereby request and authorize you, your authorized employees and or agents permission to send copies, disclose and or discuss my dental health care information in your possession to the office of Alison Poulin, DDS.

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Name of dental practice, address, tel.# and email address

My authorization to release includes:

Copies of my medical, social and dental histories, clinical examination and diagnosis records, radiographs, clinical photographs, treatment plans, treatment progress records, referral and consultation recommendations and notes, diagnostic and working casts, pharmaceutical, medical and dental laboratory prescriptions and results, office notes and other related records, that would assure continuity of my dental care.

I understand I may request a copy of this authorization. By signing below, I hereby release the holder from all liability and claims pertaining to this transfer of healthcare information. I understand that any refusal to release or revocation of this consent may result in improper diagnosis or treatment. I understand that I may review all information before its release.

Signed______________________________ **Date**____________ ___________________________________

Patient **Parent Guardian or Authorized Representative**

(Release to get patient records)