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(s)and DOB:_____

_____ _____

_____ _____

Please forward the checked information below to:

Debbie Roubal DDS, PC
830 Tenderfoot Hill Rd, Suite 250
Colorado Springs, CO 80906
719-636-1933
droubal@qwestoffice.net

INFORMATION REQUESTED

Date of last visit and what was treatment:_____

_____ Copy of latest full mouth series or pano and most recent bitewings

_____ Copy of complete dental chart

_____ Any information that might be useful about past dental treatment

Purpose or need for which information is to be used

_____ Transfer of records _____ Second Opinion
_____ Other:_____

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given is accurate to the best of my knowledge. I understand I may revoke this authorization at any time, except to the extent that the action has already been taken to comply with.

_____ _____
Patient Name Date

_____ _____
Patient/Guardian Signature Date