Dental Associates of Grand Junction

Lee Gaglione, D.D.S.
Andrew Scott, D.D.S

AUTHORIZATION TO RELEASE DENTAL INFORMATION

(The execution of this form does not authorize the release of information other than the terms specifically described below.)

TO: _____ PATIENT NAME: _____

_____ DATE OF BIRTH: _____

FAX: _____

RELEASE TO**:** **Dental Associates of Grand Junction**
2642 Patterson Road
Grand Junction, CO 81506
970-242-6753
dentalassociatesofgj@gmail.com

I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency or individual named on this request.

INFORMATION REQUESTED:

_____Copy of complete dental chart (including periodontal charting)

_____Copy of dental x-rays (BWX within 1 year, FMX, Panorex within 5 years)

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:

_____Transfer of Records _____Second Opinion

_____Other, please explain_____

AUTHORIZATION: *I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, except to the event that action has already been taken to comply with it. With my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event: 180 days from the date hereof.*
OTHER CONDITIONS: a COPY of this Authorization or my signature thereon_____may, or _____may not be used with the same effectiveness as an original.

_____ _____
Patient Name (Print) Patient Signature

_____ _____
Person authorized to sign for patient State how authorized

_____
Signature Date