READINGTON DENTAL
270 Main Street Whitehouse Station. NJ 08889

Authorization to Release Dental Records

PATIENT INFORMATION:

Full Name

Street Address

City, State, Zip Code

__/__/__ Date of Birth

___-___-____ Phone

SEND RECORDS TO:

Self or Name of Dentist, Physician, Agency, Etc.

Street Address

City, State, Zip Code

___-___-____ Phone

___-___-____ Fax

☐ Send via e-mail: _____

INFORMATION TO BE DISCLOSED:

☐ Exam & Treatment Notes Date: _____
☐ Radiographs (X-rays) Date: _____
☐ Treatment Plan Date: _____
☐ Other (specify): _____

PURPOSE(S) FOR DISCLOSING INFORMATION:

☐ Continuation of Care/Consultation
☐ Attorney Inquiry/Legal Matter
☐ Insurance Claim/Application
☐ Other (specify): _____

I understand that all information I hereby authorize to be obtained will be held strictly confidential and cannot be released without my written consent. I understand that this authorization will remain in effect until revoked by me in writing.

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time by submitting my request in writing.

Print Name (Patient/Guardian): _____

Signature (Patient/Guardian): _____ Date: _____

Signature of Witness: _____ Date: _____

AUTHORIZATIONS SIGNED BY A LEGAL REPRESENTATIVE MUST INCLUDE A COPY OF THE GUARDIANSHIP PAPERS OR A POWER OF ATTORNEY.

PLEASE SIGN AND MAIL TO 270 Main Street , Whitehouse Station NJ 08889 or Fax to 908-534-1127
You may also email to schedule@readingtondental.com