**Authorization to Release Dental Information**

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Patient Name:_____ Date of Birth: _____

SSN:_____

**Release dental information from Marshall Dental Excellence, PLLC, Dr. Andrew Frerich or Dr. John Frerich**

Release dental information to: _____

Fax #:_____ Email: _____

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. I understand that the information to be released includes information regarding the following condition(s):

Information requested: (*Please check*)
- O Copy of Complete Dental Chart
- O All Treatment Rendered
- O Copy of Dental X-Rays
- O Others (Describe)

Dates Covered:
Limited to treatment dates and for condition described below:
_____

Purpose or need for which information is to be used: (*Please check*)
- O Transfer of Records
- O Second Opinion
- O 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 extent that action has already been taken to comply with it.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:
Date:_____ or specific event:_____

_____ _____
Patient Name (Print) Person authorized to sign for patient

_____ _____
Signature Date