REQUEST FOR RELEASE OF HEALTH INFORMATION

PREVIOUS DENTAL OFFICE: ____

OFFICE PHONE OR EMAIL: ____

PATIENT'S NAME: ____________________________ DATE OF BIRTH: ____________

Information to be disclosed:

€ **Entire Dental Record** (this includes completed treatment, pending treatment, periodontal charting, x-rays and any test results) for the purpose of transferring my dental care to Payson Premier Dental.

€ My dental information relating to the following treatment or condition for the purpose of a second opinion:

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This authorization expires one year from the date signed.

Authorization and Signature: I authorize the release of my confidential protected dental information, as described in my directions above to:

Payson Premier Dental
409 W. Main St.
Payson, AZ 85541
Phone: (928)472-8400
Fax: (928)472-8300
pcc@paysonpremierdental.com

Patient Signature: ____

Personal Representative Signature: ____

Relationship to Patient if Personal Representative: ______________________________

Date of signature: ________________________