PAYSON PREMIER DENTAL

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:

  _____

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: _____