Bozart
Family Dentistry

Authorizations of Release of Medical Records

Print Patient's Full Name _____ Date of Birth (day/month/year) _____ Phone Number _____

Street Address _____ City, State, Zip Code _____

Requested Records

☐ All Medical Information ☐ Progress Notes ☐ X-ray/PAN/3D Scan ☐ Pathology result

☐ Other: _____

Send Records To:	Copy Records From:
Practice Name: _____	Practice Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____
Email: _____	Email: _____

Purpose of Disclosure

☐ Referral to specialist ☐ Insurance ☐ Transfer of care ☐ Legal Investigation ☐ Disability Determination

☐ Second Opinion ☐ Coordination of Care ☐ Other: _____

I understand that I may revoke this authorization at any time, in writing, and that the revocation will not apply to information that has already been released. Unless otherwise noted, this authorization will expire one year from the date on which it was signed.

Processing this request will require a minimum of 10-14 business days

Date: _____ Patient: _____

Date: _____ Witness: _____

_____ OFFICE USE ONLY _____

Date Completed: _____ *Signature:* _____

(Please check all that apply) ☐ *Mailed* ☐ *Picked Up* ☐ *Faxed*