Robison Associates
3235 Templeton Gap Road
Colorado Springs, CO 80907
719-630-7727 receptionist@robisondental.com

AUTHORIZATION TO RELEASE DENTAL INFORMATION

Date:______________________________

To: ______________________________

From:
Patient Name: __________________
Date of Birth: __________________

I request and authorize that the above-named doctor or health care provider to release the information specified below to Dr. Letha Robison. I understand that the information to be released includes information regarding the following condition (s):

____ Drug Abuse, if any
_____ Alcoholism or alcohol abuse, if any

____ Sickle Cell Anemia, if any
_____ Psychological or psychiatric conditions, if any

INFORMATION REQUESTED

____ Copy of complete dental chart
____ All treatment rendered in this office or by this doctor
____ Copy of dental x-rays
____ Study models, if applicable

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

____ Transfer of Records
____ Second Opinion

____ Other

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given 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. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event; on __(date supplied by patient): or __ revoked in writing by patient; or __ 180 days from the date hereof; or __ under the following conditions:

OTHER CONDITIONS: A copy of this Authorization of my signature thereon: _x_may, ___ may not be used with the same effectiveness as an original.

____
PATIENT NAME (PRINT)

PERSON AUTHORIZED TO SIGN FOR PATIENT:

______ DATE

__________________ PATIENT SIGNATURE

________________________ AUTHORIZED SIGNATURE

How Authorized: ____________________