Dental Health Clinic P.A.
20 South Minnesota Street New Ulm MN 56073
PH: (507) 359-2047 FAX: (507)354-3510 EMAIL: dhc@nudentalhealth.com

Print Name: _____ DOB:_____

Authorization to Release Information TO Dental Health Clinic

☐ Last bitewings, Pan and FMX ☐ Account information (to include insurance and financial information)

☐ Patient records: to include date of last prophy (including type) x-rays, exam and most recent probing chart.

When emailing x-rays, please include patient's name and date x-rays were taken.
Previous Dental Office/Person/Organization information is to be released from:

Name:_____

Phone:_____

Email:_____

Authorization to Release Information FROM Dental Health Clinic

Dental Office/Person/Organization information is to be released to:

Name: _____

Phone: _____

Email: _____

You have the right to revoke this authorization at any time; however, your revocation must be in writing. The revocation does not include information that has already been released prior to the written request.

Any information released pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by this rule.

This release is applicable for 1 year from date signed.

_____ _____
Signature Relationship (if other than patient)

_____
Date