Dental Health Clinic P.A.

PO Box 414
New Ulm MN 56073
(507) 359-2047
(507)354-3510 fax
dhc@nudentalhealth.com

Authorization to Release Information

Patient Name: _____

Information to be released (check all that apply)

☐ Last bitewings, Pan and FMX

☐ Account information
(to include insurance and financial information)

☐ Patient records: to include date of last prophy (including type) xrays, exam and most recent probing chart. Please include any unfinished proposed treatment.

When emailing x-rays, please include patient's name and date x-rays were taken.

Person/organization information is to be released to/from:

Name:_____

Phone:_____

Email:_____

This authorization expires 1 year from date below

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.

_____
Print Name

_____
Signature

_____
Relationship (if other than patient)

_____
Date