Office@SistersDental.com

SISTERS DENTAL

Dr. Trevor Frideres, DMD Dr. Kellie Kawasaki, DMD

RECORD RELEASE AUTHORIZATION

Patient Name: _____ DOB: _____

Name of person initiating this authorization:_____
(If not the patient, please specify your relationship with the patient)

Answer yes or no to each question below to indicate what information can be used or disclosed:

Yes / No Disclose my entire dental record, including radiographs and periodontal charting

Yes / No Disclose my dental information ONLY related to the treatment or condition specified; list treatment or condition:_____

What is the purpose of this use or disclosure? (Check all that apply)

- ○ Treatment, payment, or healthcare operations
- ○ To the family members listed here : _____
- ○ Other (describe each purpose of the requested use/disclosure in detail): _____
  _____

Name of dentist/doctor office to release records:_____
Phone number or email address:_____

Release records to Sisters Dental (office@sistersdental.com)

Yes / No

This authorization will (Check one)

- ○ Not expire
- ○ Expire on this date:_____

Authorization and Signature: I authorize the release of my confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary and that the information to be disclosed is protected by law. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information.

Patient Signature_____ Date_____
(If minor, parent or guardian must sign)