REQUEST FOR DENTAL RECORDS RELEASE AUTHORIZATION

Lindsey DENTISTRY
261 MAIN ST. CLAYSVILLE, PA

I, _____ ,

authorize _____
(Previous/Current Dental Office)

_____
(Address)

_____
(City, State, Zip Code)

_____
(Phone #)

_____
(Fax #)

to release copies of my dental records with respect to any dental care and treatment to:

Lindsey Dentistry PLLC

PO Box H - 261 Main St. Claysville, PA 15323

Phone/FAX: (724) 663-7735 EMAIL: Practice@LindseyDentistry.com

I understand that the specific type of information to be disclosed may include a detailed report of examinations, findings, treatments, prognosis, and/or x-rays, which pertain to me and my past, current, and ongoing oral health.

I hereby release Lindsey A. George, DDS & Lindsey Dentistry PLLC from all legal responsibility or legal liability that may arise from the release of such information. I understand that I may revoke this consent at any time, except that the action has been taken in reliance upon it, and that in any event this consent shall expire ninety (90) days after the date below.

A reproduced copy of this authorization shall be as valid as the original.

Patient Printed Name_____ DOB_____

Patient Signature_____
(Patient/Legal Guardian)

Relationship to Patient:_____

Patient Address: _____ Date: _____