Hamilton Advanced Dentistry

129 Copper King Ct
Hamilton, Montana 59840
406-363-2421
406-363-4541 (fax)

Authorization to release dental information

The execution of this form does not authorize the release of information other than that specifically described below.

To: _____________________

Patient's name: ____________________________ **Patient's D.O.B**.: _____________

Please release records to Hamilton Advanced Dentistry.

I request and authorize the above named doctor or health care provider to release the information specified below to the organization, agency, or individual named in this request. 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 condition

Information requested:

_X_ Copy of complete dental chart
_X_ Copy of all dental radiographs
___ Other (models, etc.) describe: ____

Purpose or need for which information is to be used:

_X_ Transfer of records
____ Second opinion
___ Other

*If possible, please email all requested information to: **office@hadmt.com**

Authorization: I certify that this request has been made voluntarily and that the information given above 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. A copy of this authorization or my signature thereon may ______ may not _____ be used with the same effectiveness as an original.

Patient's signature: __________________________ **Date**: _______________

Witness: ___________________________________