The Bryan Dental Group General Dentistry

Dental Records Release Authorization Form

Patient Information

- Full Name: _____
- Date of Birth: _____
- Phone Number: _____
- Email Address: _____

Previous Dental Office (Releasing Records From)

- Office Name: _____
- Address: _____
- Phone: _____
- Fax/Email: _____

Receiving Dental Office (Send Records To)

- Office Name: _____
- Address: _____
- Phone: _____
- Fax/Email: _____

Records to Be Released *(Check all that apply)*

☐ Complete Dental Record ☐ Treatment Notes ☐ Radiographs ☐ Billing / Insurance Records

☐ Other: _____

Purpose of Release

☐ Continuation of Care ☐ Insurance ☐ Personal ☐ Other: _____

Authorization & Consent

I hereby authorize the above-named dental office to release my dental records to the receiving office listed above. I understand that:

- This authorization is voluntary
- I may revoke this authorization at any time in writing
- Revocation will not apply to information already released
- The information disclosed may be subject to redisclosure by the recipient

Patient or Legal Representative

Date: _____

Name: _____

Relationship to Patient: _____

Signature: _____

Expiration of Authorization is one year from date of signature

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