Michael K. Sakuda, DDS, LLC

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AUTHORIZATION TO RELEASE DENTAL INFORMATION

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

Patient Name: _____
First Middle Last

Date of Birth: ____/____/_____ **SS#:** _____-____-_____

I hereby authorize _____ DDS to release the information specified below to **Michael K. Sakuda DDS, LLC.** I understand that the information to be released includes the information regarding the following condition(s):

Please Initial:

_____ Most Current X-rays, including most recent FMX/Pano

_____ Complete Dental Chart

_____ Dental Treatment Notes

The Purpose for which information is to be used:

_____ Transfer of Records

_____ Second Opinion

_____ Other, Please explain: _____

This authorization is effective now and will remain in effect until _____. If left blank this authorization will never expire.
date

I understand I may revoke this Authorization at any time, except to the extent that action has already been taken to comply with it. I understand that I may receive a copy of this authorization.

A COPY of this Authorization or my signature thereon may be used with the same effectiveness as an original.

_____ _____
Signature Date

_____ _____
Person Authorized to Sign for Patient (Print) Relationship