Authorization to Release Dental Information
To Sunnyside Dentistry

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

Patient(s) Name____ **Date of Birth** ____________

____ **Date of Birth**____________

Previous Dentist:
Name:

____

Address:

____

Phone: ____________________ **Fax:** ____________________ Email:____________________________

Release To:
Sunnyside Dentistry
14210 SE Sunnyside Road Suite 200
Clackamas, Or 97015
Phone: 503-558-9828 **Email: Office@hikadedental.com**
Fax: 503-558-9829 **_Website www.sunnysidedentistry.com**

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):

Information requested:

_________Copy of dental radiographs
_________Other (models, etc...) describe: ____________________________

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, but in any event on____________ if revoked in writing by patient: or 180 days from the date hereof: or________ under the following conditions:

List conditions:

Other conditions: A copy of this authorization, or my signature thereon may__________ may not _________ be used with the same effectiveness as an original.

Signature______________________________Date______________________