AUTHORIZATION TO RELEASE DENTAL INFORMATION

Patient Name: _____

Date of Birth: _____

SSN #: _____

Release to:

Jason L. Heiken, DDS, PC
10111 Inverness Main Street
Suite E
Englewood, CO 80112
drheiken@outlook.com

I request to authorize _____
To release the information specified below to Dr. Heiken, DDS, PC.

INFORMATION REQUESTED:

_____ Copy of complete dental chart

_____ Copies of all current X-rays (Pano, BW's)

PURPOSE FOR WHICH IS TO BE USED:

_____ Transfer of Records _____ Second Opinion

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.

_____
Patient Name (Print)

_____
Patient or Guardian Signature

_____
Date