Croasdaile
DENTAL ARTS
Your Smile. Our Passion.

Drs. Turner & Butler, DMD, PA
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RECORDS RELEASE

Patient Name: _____
Address: _____
Date of birth: _____

I hereby authorize the release of copies of my dental records:_____
I hereby authorize the release of copies of my dental x-rays:_____

To: Drs. name: _____
Address: _____
Telephone:_____
Drs. Email Address: _____

This authorization shall be in effect until the information has been forwarded or requested.

Rights of the Patient

I understand that my treatment will not be conditioned on signing the authorization and that I have the right to refuse to sign the authorization. I understand that the information disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization by sending a written notification to the address above and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document.

Patient Signature Date

Updated 05/24/17