**Authorization for the Release of Dental Records**

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I hereby authorize **Cynthia B. Creech, DDS** to release the information in the dental record of

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to

(patient’s name)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of dentist, physician, clinic, or patient’s representative)

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(Address/Email address)

Any and all information may be released including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below.

This authorization is effective now and will remain in effect for 90 days. I understand that I may receive a copy of this authorization.

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Signature Date

If not signed by the patient please indicate relationship:

□ parent or guardian of minor patient

□ guardian or conservator of an incompetent patient

□ beneficiary or personal representative of deceased patient

**NOTE:** This authorization is intended to comply with applicable state laws. It is not intended as a “Consent” or “Authorization” for the use and disclosure of Protected Health Information (PHI) under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or its implementing regulations. The medical provider to whom this authorization is directed should ensure that he or she is in compliance with applicable HIPAA requirements before releasing the requested records.

***Place a copy in the patient’s chart.***