Frederick Guerra, Jr,. DMD
General, Family & Cosmetic Dentistry
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AUTHORIZATION TO RELEASE DENTAL INFORMATION

Dear Dr _____:

Please forward a copy of my/ my family dental records to:

Mail to: Frederick Guerra, Jr,. DMD, 3208 North Academy Blvd., Ste. 100, Colorado Springs, CO 80917,
Email to: office@guerradental.com

Patient:_____Patient:_____Patient:_____

DOB:_____/_____/_____ DOB:_____/_____/_____ DOB:_____/_____/_____

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 on this request. I understand that the information to be released includes information regarding the following condition (s)

INFORMATION REQUESTED:

_____ Copy of complete dental chart

_____ Copy of dental X- rays

PURPOSE (S) OR NEED FOR WICH INFORMATION IS TO BE USED:

_____ Transfer of Records _____ Second Opinion

AUTHORIZATION: I certify that his request has been made voluntarily and that the information given is accurate to 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 ____ (date supplied by patient); or X revoked in writing by patient; or ____ 180 days from the date hereof; or ____ under the following conditions:

OTHER CONDITIONS: A copy of this Authorization or my signature thereon: X may, ____ not be used with the same effectiveness as an original.

_____ _____
PATIENT NAME (print) DATE

_____ _____
PATIENT SIGNATURE DATE