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

TO:Altura Periodontics

PATIENT
Name:

DOB:

SS#:

RELEASE TO:

I request and authorize the above-named doctor of 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 conditions):

Drug Abuse, if any
Sickle Cell Anemia, if any
Alcoholism or alcohol abuse, if any
Psychological or psychiatric condiitons, if any

INFORMATION REQUESTED:

___ Copy of complete dental chart

___ Copy of dental x-rays

___ Other (e.g. models - describe) _____

DATES COVERED:

___ All treatment render in this office or by this doctor

_____ * Limited to treatment dates & for conditions described below:

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

_____ Transfer of records
Other

___ 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. 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 ___ if 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 __may,_____may not be used with the same effectiveness as an original.*

_____ _____

PATIENT SIGNATURE DATE