Authorization for the Release of Dental Records

I hereby authorize _____, DDS to release information in

the dental record of _____DOB____/____/___ to

(patient's name)

Denali Dental Associates, LLC
1901 Airport Way, Suite 103
Fairbanks, AK 99701
(907) 452-1737 Fax (907) 374-9961

PLEASE FORWARD ANY CURRENT BWX AND FMX/PANOREX IF TAKEN WITHIN THE PAST 5 YEARS. ALSO SEND RECORD OF ALL PAST TREATMENT AND CURRENT RECOMMENDATIONS IF ANY.

This authorization is effective now and will remain in effect until _____ (date), or until I request otherwise. I understand that I may receive a copy of this authorization.

_____ _____

Signature Date

If not signed by the patient please indicate relationship:

- o Parent or guardian of minor patient
- o Guardian or conservator of an incompetent patient
- o 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 (HIPPA) or its implementing regulations. The medical provider to whom this authorization is directed should ensure that he or she is in compliance with applicable HIPPA requirements before releasing the requested records.

If possible, please e-mail digital x-rays and copies of chart & treatment history to office@denalidentalAK.com