
**RELEASE OF RECORDS AUTHORIZATION FORM**

First Name:_____ Middle Name:_____ Last Name:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Phone Number:_____ Birthdate (mm/dd/yyyy):_____

Social Security Number (last 4 digits):_____

Dental Record Number:

I, _____ authorize Madden Dental to release the following medical and/or dental information to: _____ for the following purpose: _____ (or at the request of the individual).

This release is effective for 1 year from the date of execution; however, I may revoke it at any time by providing notice in writing to the above named party. I acknowledge receiving a completed copy of this release.

A copy of this form is acceptable authorization for the release of the above described information.

Notices to Person Authorizing Disclosure

Except for certain research purposes, the completion of this authorization is not required prior to the provision of treatment.

The information released pursuant to this authorization may be subject to re-disclosure and may no longer be protected by federal or state privacy laws.

Printed Name:_____

Signature:_____

Patient/Legal Representative/Officer of the Court Authorizing Disclosure

Date:_____

Relationship to Patient:_____