LASER PERIODONTICS & DENTAL IMPLANTS

Neda Azadivatan D.D.S.

TO RELEASE DENTAL INFORMATION

TO: _____ PATIENT NAME: _____

FAX: _____ DOB: _____ SSN: _____

RELEASE TO: _____

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: DATES COVERED:

*Limited to treatment dates and for:

_____Copy of complete dental chart condition described below:

_____Copy of dental x-rays

_____All treatment rendered

_____Others (e.g. models—describe)

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.*

Patient Name (Print)

_____

Person authorized to sign for patient State how authorized

_____

Signature Date