DAG ZAPATERO, D.D.S., M.A.G.D.

General | Cosmetic | Restorative | Implant | Geriatric Dental Care

DENTAL RECORDS RELEASE

I AUTHORIZE:

Sender: _____

Address: _____

City/State/Zip code: _____

RELEASE TO:

Destination: _____

Address: _____

City/State: _____

FOR THE PURPOSE OF (circle one): Consultation Second Opinion Continued Care.

Type of information to be released (check all that apply):

☐ Dental X-rays ☐ Dental Records / Progress Notes ☐ Biopsy Reports ☐ Other:

PATIENT INFORMATION

Patient's Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Daytime Telephone: (_____) _____

As the person signing this consent, I understand that I am giving my permission to Dag Zapatero, D.D.S., M.A.G.D. for disclosure of confidential health care records as specified above. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not re-disclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law.

Today's Date: _____ This consent expires on (date): _____

_____ _____

Patient Signature/Parent or Legal Guardian (when required) Date

_____ _____

Witnessed By Date