Consent for Release
Patient Record Information

PATIENT INFORMATION
I hereby authorize Your Smile, to release the information from the dental record(s) of:

____
(Print name of patient)

There is a charge of $20.00 for the release of Digital Radiographs. You may choose to have the these radiographs mailed, E-mailed or copied to a C.D. , please allow 48 hours for records to be duplicated before pick-up or mailing.

This release may include information regarding communicable diseases such as Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS), Psychiatry, Drug, and/or Alcohol Abuse, unless specifically requested to be omitted.

Covering the period(s) of dental treatment: ____________________________________

Birth Date: ____________ Social Security #:_________________

Purpose of Release: ____

INFORMATION TO BE RELEASED
- ○ Copy of progress notes only.
- ○ Copy of radiographs* only.
- ○ Copy of complete dental record. (history, exam, diagnoses, treatment plan and radiographs*.)
- ○ Copy of other (please specify): ____________________________________*
  *fees may apply.

This information is to be released to: _____________________________________
(Must include address)
____

AUTHORIZATION

I understand this authorization is valid for a period of ninety (90) days or until expressly revoked by me. I understand that I may withdraw this authorization by submitting a written, dated request, and that such revocation does not affect action that already has been taken based on this authorization. Records and radiographs will be held until account is paid in full.

Signed:

___________________________________ ___________________________________ Date: _________
(Patient, Parent, or Legal Representative) (Relationship to patient)

___________________________________ Date: _________
(Witness)

□ **$20.00** □ **Other:** ________

1331 Bel Air Road
Bel Air MD 21014
Fax. 410.877.3079 Tel: 410.877.3000

PAYMENT METHOD
- ○ Cash
- ○ Master Card/Visa/Discover*
- ○ Care Credit

*Credit Card #: ____ Exp: ___/___ V/Security Code __ __ __

Name on Card: ________________________________ Signature: ____

Billing Address: ____
____