ZAHNER DENTAL
QUALITY FAMILY DENTAL CARE

Authorization to Release Dental Records

Patient's name: _____ Date of birth: _____

SSN: _____ Previous name: _____

I request and authorize _____ to release health care information of the patient named above to:

Kristin@zahnerdental.com
Zahner Dental, LLC
3 Main Street, Ellington, CT 06029
Telephone: 860-870-9031

Please forward the following x-rays if available:

□ Full Mouth Series Date Taken_____

□ Panorex Date Taken_____

□ Bitewings Date Taken_____

Please provide the following information:

□ Date of last cleaning: _____

□ Date of last examination: _____

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement. I can:

1. Sign and date a form available from the doctor or practice called "Revocation of Authorization for Use and Disclosure of Health Care Information" or

2. Write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter.

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

_____ _____
Signature of patient or patient's authorized representative Date

Relationship or status if signed by parent, legal guardian, personal representative, etc.: _____