Release of Medical/ Dental Records

Patient Name: _____

Date of Birth: _____

Phone Number: _____

AUTHORIZATION TO RELEASE RECORDS *(Release of records from Anchor Periodontics)*

I authorize **Anchor Periodontics** to release my medical and/or dental records as indicated below.
Records To Be Released (check all that apply):
☐ Periodontal Records
☐ Dental Records
☐ Radiographs / Images
☐ Treatment Notes
☐ All Records

Records To Be Released To:_____

Provider / Office Name: _____

Phone: _____ **Fax:** _____

AUTHORIZATION TO REQUEST RECORDS *(Request records from another office to Anchor Periodontics)*

I authorize **Anchor Periodontics** to request and obtain my medical and/or dental records from the provider listed below.

Records To Be Released To:_____

Provider / Office Name: _____

Phone: _____ **Fax:** _____

Records To Be Requested (check all that apply):
☐ Periodontal Records
☐ Dental Records
☐ Radiographs / Images
☐ Treatment Notes
☐ All Records

This authorization permits the exchange of records by **mail, fax, electronic transmission, or verbal communication** for the purpose of treatment and coordination of care.
I understand that:

- This authorization is voluntary and may be revoked in writing at any time.
- Information disclosed may no longer be protected by HIPAA once released.
- This authorization is valid for **one (1) year** from the date signed unless revoked sooner.

AUTHORIZATION

Patient /Guardian Signature: _____ **Date:** _____

Printed Name: _____ **Relationship:** _____

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