AUTHORIZATION AND CONSENT TO RELEASE DENTAL RECORDS

TO DENTAL CONNECTIONS, INC.

Patient name: _____

Address: _____

City, State, Zip: _____

Birth date/Social Security #: _____

The above-named patient authorizes your dental office, its members, and employees to furnish a copy of his/her dental records to

Dental Connections, Inc.
1111 9th Street, Suite 190
Des Moines, Iowa 50314
E-mail: afriedmann@dental515.com

The patient understand that "dental records" includes, but is not limited to, any and all reports, notes, memoranda, doctors' notes, assistant and clerical staff notes, hospital records, x-rays, laboratory and test reports, and emergency room records.

Specific authorization for release of information protected by state or federal law:

Please mark the following if any relate to you and you would like release of this health information to be included in your record release. If the boxes below are not marked, this information will not be released as part of your request.

☐ HIV ☐ Mental Health ☐ Substance Abuse

☐ Information Including AIDS and related testing

By signing this form, the patient releases and agrees to hold harmless your dental office from any and all responsibility and liability that may arise from complying with this authorization and consent to release the patient's dental records. The patient further understands that your office has no control over the release or distribution of the requested dental records by those persons or entities to which copies of the records are being released.

This authorization expires one year from the signature date

_____ Date: _____
Signature of patient, parent, or legal guardian

_____
Relationship to patient and authority to give consent