Request for and Authorization to Release Dental Records or Health Information

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I request and authorize Matthew S. Ames, DDS, MS, PLLC to release information specified below to the organization or individual named on this request. (Please complete all portions.)

Records held by this office to be released to:

Name:____

Address: ____

Please release:

- ☐ Complete clinical and lab records held by this office.
- ☐ A specific portion/section of the patient record. Please specify below:

  ____

  ____

  ____

Reason for request:

- ☐ Coordinate care with another medical or dental professional
- ☐ Personal records
- ☐ Transferring out of practice. If so, please let us know whether:
  - o Moving
  - o Other. Please specify:____
- ☐ Other. Please specify:____

Patient's First Name:____________________ Middle:_______ Last:________________________

Patient's Birth Date:_______________________ Patient ID Number:_________________________

Phone number to contact with any questions about this release:______________________________

Is Patient 18 Years Old or Older?

- ☐ Yes

  Patient Signature:____ Date:___________
- ☐ No

  Signature of Legal Guardian__________________________________Date:___________