Consent for Information Release

_____ _____

Patient's Name Date of Birth

_____ _____

Social Security Number Today's Date

I hereby authorize:

_____

Current office or Doctor's Name

To release the following confidential information regarding the patient's care, treatment and services:

__ Complete Dental Chart (including all progress notes, treatment notes and treatment plan)

__ Xrays/Photos

__Models

__Other (e.g. Insurance information, etc. please describe)

Purpose of release: Continuation of care: ___ Second Opinion: ___ Other: _____

My records are to be released to:

Legacy Family Dental
Melissa D. Mariani, D.D.S. & Naimisha Shah Hoffman, D.D.S.
6655 Post Road Suite A.
Dublin, Ohio 43016
Please email to: Info@legacyfamilydentaldublin.com
Phone 614-336-7643
Fax 614-336-7653

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. I understand this consent will expire if records have been successfully released, if the patient revokes this consent in writing with a date and signature, or in 180 days from this date _____.

_____ _____ _____

Signature of Person Authorized to Consent Date Relationship to Patient