Legacy Family Dental

Consent for Information Release

I, _____ hereby authorize the following practice to release the following confidential information regarding my care, treatment, and services to be released to **Legacy Family Dental**:

Previous Dental Office or Dentist:	Records being requested:
_____ _____ Phone: _____ FAX: _____	____ Complete Dental Chart (including all treatment notes, periodontal charting, and treatment plan) ____ Xrays/Photos (Dates)

Patient's Name **(Please Print)** Date of Birth

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Patient's Name **(Please Print)** Date of Birth

Purpose of release: (Please select one)	Legacy Family Dental
____ Continuation of care ____ Second Opinion	Melissa D. Mariani D.D.S. Naimisha Shah Hoffman D.D.S. Ashley Place D.D.S. **6655 Post Road Suite A.** **Dublin, Ohio 43016** **Phone:** (614) 336-7643 **Fax:** (614)-336-7653

Please email to: Info@legacyfamilydentaldublin.com

_____ _____ _____

Signature of Person Authorized to Consent Date Relationship to Patient

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 signed date.