RELEASE OF DENTAL INFORMATION

I hereby authorize the release of dental records and/or x-rays from the office of CITY CREEK DENTAL from the record of:

Patient Name: _____ DOB: _____
SSN: _____ Pt Phone: _____
Address: _____
_____

TO:

Office/Practice Name: _____
Address: _____
_____
Phone: _____
Fax: _____
Email: _____

Reason for record transfer _____

I understand that to the extent any Recipient of this information, as identified above, is not a "covered entity" under Federal or Texas Privacy law, the information may no longer be protected by Federal and Texas Privacy law once it is disclosed to the Recipient and, therefore, may be subject to re-disclosure by the Recipient.

I understand that I may revoke this authorization in writing at any time except to the extent that CITY CREEK DENTAL has already relied on this authorization. I understand that I may revoke this authorization by providing CITY CREEK DENTAL a written request for revocation stating my intent to revoke this authorization.

If information is being released directly to me, I understand that my dental record may contain reports, test results and/or notes that only a licensed dentist can interpret. I understand and have been advised that I should contact CITY CREEK DENTAL regarding the entries made in my dental record to prevent my misunderstanding of the information that has been written in the record. I will not CITY CREEK DENTAL liable for any misinterpretation of the information in my dental record as a result of not consulting CITY CREEK DENTAL for the correct interpretation.

I understand that the information released is for the specific purpose stated above and my not be provided in whole or part to any other agency, organization or person.

_____ _____
Signature of patient or Legal Representative Date

_____ _____
Representative's authority to Act for Patient Witness