AUTHORIZATION TO RELEASE DENTAL INFORMATION

(the Exection fo the form does not authorize the release of information other than that specitically described below)

PATIENT: Release To : Bruce H. Johnson D.D.S.

Name: 8246 W. Bowles Avenue Suite S

DOB: SSN Littleton, CO 80123

 Phone: 303 989-0577 Email: info@brucehjohnsondds.com

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I request and and authorize the above-named doctoe or health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be relseased inculdes information regarding the following conditon(s):

\_\_\_\_Drug Abuse, if any \_\_\_\_Alcoholism or alcohol abuse, if any

\_\_\_\_Sicikle Cell Anemia, if any \_\_\_\_Psychological or Psychiatic conditions, if any

INFORMATION REQUESTED: DATES COVERED:

\_\_\_\_Copy of complete dental chart \_\_\_\_All treatment rendered in this office or by this doctor

\_\_\_\_Copy of dental x-rays \_\_\_\_Limited to treamtnet dates & for conditions described below:

\_\_\_\_Other (e.g modles---describe)\_\_\_\_\_\_\_\_\_\_

Purpose(s) or Need for Which information is to be used: \_\_\_\_Transfer records \_\_\_\_\_Second opinon \_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given above is complete to the best of my knowledge. I understand that I may revoke this Authorization at any time, except to the exent that actio has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon saisfation of the need for disclosure, but any event: on\_\_\_\_\_(date supplied by patient) or \_\_\_\_\_if revoked in writing by patient; or \_\_\_\_\_\_ 180 days from the date hereof; or\_\_\_\_\_under the following conditions:

OTHER CONDITONS: A copy of the Authorization or my signature theron:\_\_\_\_may,\_\_\_\_\_may NOT be usedwith the same effctiveness as an original.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PERSON ATHORIZED TO SIGN FOR PATIENT:

 PATIENT NAME (print)

\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE PATIENT SIGNATURE State how Authorized:\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_