CASTLE ROCK DENTAL HEALTH

2 OAKWOOD PARK, SUITE 206, CASTLE ROCK, CO 80104
P. 303.663.9600 F. 303.663.9627

AUTHORIZATION TO RELEASE DENTAL INFORMATION

PATIENT: _____ RELEASE TO: _____

DATE OF BIRTH: _____ RELEASED BY: _____

Please Email Records To: Admin@castlerockdentalhealth.com

I request and authorize Dr. Walt Vogl or the above mentioned health care provider to release the information specified below to the organization, agency or individual named on this request form. I understand that the information to be released may include personal health information protected by HIPPA Privacy Laws. I am requesting:

___Copy of dental x-rays

___All treatment rendered in this office or by this doctor.

___Copy of Dental Charting

___Account information

___Other:_____

The reason this information is being requested:

___Transfer of Records

___Second Opinion

___Other:_____

Patient Signature: _____

Relationship to Patient: _____

Signature of Patient or Legal Guardian: _____ Date: _____