Dr. Soules D.D.S., Inc.

Authorization For Release of Dental Records

Directions: Please print clearly and provide all information requested. An individual request must be completed and signed by the patient unless a minor.

Patient Name:_____ Social Security Number:_____

Date of Birth:_____

I am requesting that my dental records be sent to the address listed below. I understand that this request requires my signature as an indication of consent for the office to release a copy of my records. Records are legally considered the property of the dental practice and remain under patient the guardianship of this office until no longer required by state law; however, as a patient, I have a right to a copy of my records.

- ❑ I, _____ hereby authorize the release of my duplicate records

Release the record(s) to the following person(s):

- ❑ Myself (ID Required)
- ❑ Doctor (list name and address): _____
  _____
  _____
- ❑ Facility (list name and address): _____
  _____
  _____
- ❑ Other (list person/s and relationship): _____
  (ID required)

I understand that by my signature, I am releasing Lana Soules, D.D.S., Inc. from all legal responsibility for their use by other parties. I understand that there is a processing fee of $15.00 and an additional fee of $.60 per page for copying. I also understand that I am entitled to a copy of the record requested within 30 working days of the Practice's receipt of the request and payment. Payment will be made in the form of cash, check, or credit card. The records will be mailed to the above address, or made available for pick up upon receipt of payment. If you are transferring out of the practice, please satisfy any outstanding balance on your account.

Patient signature:_____ Date:_____

Print name:_____

Relationship to patient if minor:_____

Expiration date is 1 year from signature date. This authorization may be revoked at any time, upon written request by authorized individual. The practice is not liable for information released to a valid authorization and prior to revocation.

While we understand that you are not obligated in any manner to provide us with a reason, we would appreciate knowing more about your decision to leave our practice.

- ❑ Leaving the area
- ❑ Office hours
- ❑ Change of insurance
- ❑ Office convenience (location)
- ❑ Patient satisfaction issues
- ❑ Other

For Office use only

Date Release _____ By_ _____ copy of ID_____(initial)