CLEAR LAKES
DENTAL

Please email this form to **info@clearlakesdental.com** upon completion or send via fax.

Concordia St. Paul Fax #	Downtown St. Paul (PHA) Fax #	Robbinsdale Fax #
(651) 444-8955	(651) 340-6974	(763) 273-4654

AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

For Patient: _____ DOB: _____

I hereby authorize release of my health/dental information to the individual/organization named below for the reasons:

Records to be released to: _____

email:_____

Records to be sent from: _____

email: _____

Information to be released: (**circle** all that apply)

History / Examination records X-rays Account Statement

Other (please list)

_____

_____

_____

_____

I understand that this authorization may be revoked in writing at any time prior to expiration date except if this office has taken action relying on this authorization. I understand that the information disclosed in relation to this authorization may be redisclosed by the recipient and could no longer be subject to protection by HIPAA privacy rules. I understand that I may receive a copy of this authorization upon request.

Signature _____ Date _____

Relationship to patient if not signed by patient _____