

**Dental Care of Morristown**

**AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION**

First Name: \_\_\_\_\_

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_

DOB: \_\_\_\_\_

I authorize Dental Care of Morristown to release my medical records to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

I authorize Dental Care of Morristown to release my medical records to:

€ All medical sources, including any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf

Please release the following documentation:

- € Complete Chart
- € Discharge Summaries
- € Consultations
- € Lab Work
- € X-Rays
- € Skin Tests
- € Other: \_\_\_\_\_

This authorization, as may be applicable, extends to any medical records covered by any privilege, including without limitation to psychiatric, psychological and mental testing and records; records relating to drug treatment and/or substance abuse; records related to sexually transmitted diseases and/or social service notes.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED**

\_\_\_\_\_ First Request

\_\_\_\_\_ Second Request

\_\_\_\_\_ Third Request