Authorization for Release of Dental Records

Island Health Care

I, (print patient name) _____, hereby authorize the doctors and staff of Island Health Care Dental Center to release records or knowledge concerning my dental health to the provider/facility listed below:

Dental Provider		
Facility Address		
Phone	**Fax**	**Email**

Information Requested:	**Reason for Disclosure:**
❑ STD, STI or HIV results ❑ Substance Use Disorder ❑ Other (please specify below):	❑ Transfer of care ❑ Second opinion ❑ Other (please specify below):

Authorization will expire in 1 year unless written revocation is received prior to expiration date.

Name of Patient (Print)	**Patient Date of Birth**
Name of Representative (if signing on patient's behalf)	**Relationship to Patient** (if signing on patient's behalf)
Signature of Patient / Representative	**Date**