# Authorization to Obtain/Request Dental Records

Island Health Care

I, (print patient name) _____, hereby authorize the doctors and staff of the following dental provider (please enter information for the provider you're requesting records FROM):

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

to release records or knowledge concerning my dental health to Island Health Care Dental Center:

**Address:** Island Health Care Dental Center, P.O. Box 9000, Edgartown, MA 02539
**Phone:** 508-939-9358 (option 7) **Fax:** (508) 939-8644 **Email:** HIM@ihimv.org

| **Information Requested:** | **Reason for Disclosure:** |
|---|---|
| ❑ Copy of complete dental chart<br>❑ Copy of dental x-rays<br>❑ Other (please specify below): | ❑ Transfer of care<br>❑ Second opinion<br>❑ 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** |