



## AUTHORIZATION TO DISCLOSE DENTAL HEALTH INFORMATION

I, the undersigned, authorize East Towne Dental Associates to disclose the information described below to the recipient(s) described below. I understand and agree to the statements and information contained in this authorization.

### PATIENT INFORMATION

Patient Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Patient Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Other Names During Treatment: \_\_\_\_\_

### RELEASE INFORMATION

Please complete this section and check mark next to the appropriate to/from box for the request to be processed:

☐ Release Information to ☐ Request Information From

Name/Facility: \_\_\_\_\_ Attention: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Purpose of Request \_\_\_\_\_

### INFORMATION TO BE RELEASED

Please provide information in my dental health records for dates: From: \_\_\_\_\_ To: \_\_\_\_\_  
Place a check mark next to the requested records:  
☐ Complete dental chart ☐ Dental Radiographs Other: \_\_\_\_\_

### AUTHORIZATION TO RELEASE PROTECTED INFORMATION

**Required** - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Place a check mark next to the requested records:

☐ Complete dental chart ☐ Dental Radiographs Other: \_\_\_\_\_

**Authorization:** I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge.

Patient/Guardian Name \_\_\_\_\_ Date \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_ Relationship \_\_\_\_\_

*If a personal representative executes this authorization, then the authorization must contain a description of the representative's authority to act for the individual, e.g., "parent" or "guardian ad litem"*

### East Towne Dental Associates

11501 N Port Washington Rd, Suite 102, Mequon, WI 53092  
T: 262.241.8880 • F: 262.241.5250 • E: [contactus@easttownedentalassociates.com](mailto:contactus@easttownedentalassociates.com)