LOGOS DENTISTRY
GENERAL, FAMILY & COSMETIC DENTISTRY

AUTHORIZATION FOR THE RELEASE OF DENTAL INFORMATION

Patient's Name:_____ Date of Birth:_____

Address:_____Today's Date:_____

Phone Numbers:_____(Home)_____(Mobile/Work)

Name of Person requesting authorization:_____Relation to Patient:_____

☐ **I authorize** _____

Address: _____

To release to LOGOS DENTISTRY, PLLC, 3195 W. Ray Road, Suite #3, Chandler, AZ 85226

information regarding: _____

(indicate what information, i.e. x-rays, treatment plan etc.)

to be used for: _____

(purpose or need for information, i.e. 2nd opinion, transfer of records, etc.)

This information may be emailed to Frontdesk@logosdentistry.com or faxed to (**480)-305-5109**

☐ **I authorize LOGOS DENTISTRY, PLLC, 3195 W. Ray Road, Suite #3, Chandler, AZ 85226**

To release to _____

Address: _____

information regarding: _____

(indicate what information, i.e. x-rays, treatment plan etc.)

to be used for: _____

(purpose or need for information, i.e. 2nd opinion, transfer of records, etc.)

This information may be emailed to _____ or faxed to _____

- I understand that I may revoke this authorization by written request at any time to the **Logos Dentistry, PLLC**. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization expires 1 year from the date of my signature.
- I understand that once information is released pursuant to this authorization, Logos Dentistry, PLLC cannot prevent the re-disclosure of the information to another third party.
- I understand there may be a charge associated with the release of information services rendered, which will be the sole responsibility of the individual making the request. There is no charge for release of information from Logos Dentistry, PLLC to other health care facilities for continuing care.
- Your treatment will not be conditioned on your signing this authorization.
- You are entitled to a copy of this *Authorization for the Release of Dental Information*.
- A reproduction of this signed and dated document is considered as valid as the original.

_____ _____

Patient, Parent or Legal Guardian Signature (please circle) Date