



Authorization to Release Dental Records

Office: ☐ **Grand Prairie**
(972) 262-5593☐ **Arlington**
(682) 284-1120☐ **Commerce**
(903) 246-4424☐ **Paris**
(903) 609-0567

Use this form to have dental records sent to you, to another dentist or doctor, or to anyone else you choose.

Patient name (first and last)

Date of birth (MM/DD/YYYY)

Phone

Email

Address

Release records from

Name of person, dentist or office

Phone

Address

Fax or email

Send records to

Name of person, dentist or office

Phone

Address

Fax or email

Records to release

☐ Complete dental record☐ Treatment plans☐ X-rays and images☐ Billing and payment records

Other records

From date

To date

Format: ☐ Paper copy ☐ Electronic copy

Purpose

☐ Continuing dental care☐ At my request☐ Insurance☐ Legal☐ Other:



Expiration

This authorization expires on (date)

or when this event happens

If neither is filled in, this authorization expires one year from the date it is signed.

Your rights

- You may revoke this authorization at any time by giving written notice to the office. Revoking it does not affect information already released based on this authorization.
- Sonria Dentista will not condition your treatment, payment, enrollment in a health plan or eligibility for benefits on whether you sign this authorization.
- Information released under this authorization may be shared again by the person or organization that receives it and may no longer be protected by federal privacy law.
- A reasonable, cost-based fee may apply for copies, as allowed by law.
- Texas law: if you ask in writing for a copy of your electronic health records, the office will provide it in electronic form within 15 business days of receiving your written request (Tex. Health & Safety Code § 181.102).
- You are entitled to a copy of this signed authorization.

Signature

Signature of patient or personal representative

Date

Printed name

If representative, legal authority (parent, guardian, power of attorney)