Authorization for Dr. Murdoch to release your previous dental records

PATIENT:
(your information)

REQUEST TO:

Dr. Richard Murdoch
501 S. Cherry St. Suite #230
Glendale, CO 80246
Information@murdochdds.com

NAME: _____
DOB: _____
SSN: _____
Email address: _____

RELEASE MY RECORDS TO: (can be sent via US mail and/or email):

Doctor/Office Name: _____

Doctor/Office Address: _____

Doctor/Office City, State & Zip: _____

AND/OR Email address: _____

INFORMATION REQUESTED:

_____Copy of Dental Xrays ____Copy of Complete Dental Chart

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

____Transfer of records _____Second Opinion

Authorization: I certify this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure.

PATIENT NAME (print) _____ __PATIENT SIGNATURE_____

OR

REPRESENTATIVE NAME (print)_____ REPRESENTATIVE SIGNATURE_____

DATE: _____