AUTHORIZATION TO RELEASE DENTAL INFORMATION

(The execution of this form does not authorize the release of information other than that specifically described below.)

To: _____
_____
_____
_____
_____

Release to: Shine Dental Arts, LLC
9224 Teddy Lane
Lone Tree, CO 80124
FAX: 303-648-5433
Office: 720-776-9401
Email: shona@shinedentalarts.com

Patient Name: _____Date of Birth: _____

Information Requested:

_____

_____

_____

I request and authorize the above-named doctor or health care provider to release the information specified above to the organization, agency or individual named on this request.

I certify that 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.

A copy of this Authorization and my signature thereon: __X__ may, _____ may not, be used with the same effectiveness as the original.

_____

PATIENT NAME (print)

_____ _____

PATIENT SIGNATURE DATE