ICONIC Dentistry
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AUTHORIZATION TO RELEASE MEDICAL RECORDS

☐ Please **RELEASE** my medical information to:

☐ Please **OBTAIN** my medical information from:

Name of Doctor, Hospital or Self: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Patient Information:

Print Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

I hereby authorize the release of the information specified below:

☐ Progress note ☐ X-ray radiographs ☐ Complete medical record(s) in your possession
☐ Other, specify: _____

I understand that the authorization for disclosure of records as detailed above, unless specifically limited by me in writing, will extend to all aspects of treatment provided. ICONIC Dentistry is hereby released from all legal responsibility of liability for the release of the above disclosure of information. I have the right to withdraw this authorization at any time and that such revocation must be in writing. I further understand that, depending on the amount of time spent by office staff in the preparation of my medical records, there may be a one-time fee of $25.

Patient Signature: _____ Date: _____

Or Person Authorized to Sign for Patient: _____

Relationship to Patient: _____