Carabelli DENTAL

DENTAL RECORDS RELEASE FORM

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

AUTHORIZES: Carabelli Dental 824 N. Main Suite A Roswell, NM 88201

TO DISCLOSE TO: _____

Address: _____

Phone: _____ Fax: _____

Delivery options: ☐ In Person ☐ Mail ☐ Fax ☐ Email (encrypted)

Are you requesting records to transfer care to another dental provider? ☐ Yes ☐ No
(I understand that by checking Yes and signing this form I am requesting to no longer be an active patient at Carabelli Dental and understand that any treatment diagnosed needs to be completed by another dental facility as soon as possible.)

Only information from the past five (5) years will be disclosed. Unless dates filled in below.
From: _____ To _____

INFORMATION TO BE DISCLOSED:
Treatment plan ☐ Radiology films/images ☐

Specific records/information as follows/ NOTES: _____

_____

EXPIRATION: This Authorization is good for one year unless dates filled in below
From: _____ *To* _____

I hereby authorize Carabelli Dental to release my protected health information as listed above. I understand that once the records are released to the above party they are no longer protected by Carabelli Dental.

_____ _____ _____
Printed Name Signature Date Relationship

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