Dr. Brandon Rensch

415 Vick Ave., Raleigh, NC 27612

919-787-0355

info@cdldentistry.com

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

Patient Name: ______________________________ Date: ____________________________________

Address: __________________________________ SSN: ____________________________________

____ DOB: ____________________________________

Receive records from: Release records to:

____ ____

____ ____

____ ____

Please send a copy of my records as indicated for date(s) of treatment: ____________________

Purpose of releasing dental information: ____

I understand that my express consent is required to release any dental information relating to testing, diagnosis, and/or any procedure concerning to dental problems. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulation. This authorization can be revoked but not retroactive to the release of information made in good faith.

_____________________________________ _____________________________________

Signature of patient, parent or legal guardian Witness

____

Date

Permission to email records? **YES**_________**NO**________