

California Authorization for the Release of Dental Records

I hereby authorize _____ DDS/DMD to release
information in the dental record of _____
(Patient's name)
to _____
(Name of dentist, physician clinic, or patient's representative)

(Address) (City/state/zip)

Any and all information may be released including, but not limited to,
mental health records protected by the Lanterman-Petris-Short Act, drug
and/or alcohol abuse records and/or HIV tests, if any, except as
specifically provided below.

I understand I may receive a copy of this authorization.

Signed: _____ Date: _____
(Patient, guardian or beneficiary)

Enclosed:

- _____ Last full-mouth series
- _____ Last bitewing series
- _____ Last panoramic film
- _____ Last periodontal probing record

Last seen in our office: _____

Last prophylaxis or SRP: _____

Additional Comments: _____