DENTAL RECORDS RELEASE FORM

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

AUTHORIZES: **Idaho State Board of Dentistry**
11341 W Chinden Blvd. Boise, ID 83714

TO DISCLOSE TO: ☐ Self ☐ Dental Provider ☐ Other _____
Delivery options ☐ mail ☐ delivery ☐ email ☐ fax ☐ pick up *(please fill in below)*

To be picked up by, I hereby authorize _____ to pick up my records. (Photo ID required.)

Send to: _____
Name of Health Care Provider / Plan / Other/ Myself

_____
Address

PHONE: _____ FAX # _____

EMAIL : _____

Your treatment notes will be released, if you want us to release other information then please mark below.
INFORMATION TO BE DISCLOSED:
Treatment plan ☐ Radiology films/images ☐ All billing records ☐

Specific records/information as follows: _____

_____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED:
_____

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

SIGNATURE OF PATIENT / LEGAL REP:

_____DATE: _____
If signed by a person other than the patient, complete the following: Individual is: ☐ parent* legal guardian
☐ legally incompetent ☐ incapacitated deceased ☐ next of kin / executor of deceased