RECORDS RELEASE

(Please fill out form below and mail, fax, drop off or email to your previous office)

PATIENT (Name/Address) DOB:

AUTHORIZE:

RELEASE RECORDS TO:

Bailey Family Dental, S.C.
557 Cottonwood Avenue
Hartland, WI 53029
smile@baileyfamilydental.com

INFORMATION TO BE RELEASED:

__ Medical History
__ Treatment Notes
__ X-rays
__ Allergy Records
__ Entire Record
__ Financial
__ Appointment Scheduling
__ Prescriptions
__ Other (Specify): _____
_____

PURPOSE OF DISCLOSURE: (Check applicable categories)

__ Further Medical Care
__ Application for Insurance
__ Legal Investigation
__Personal
__Changing Dentist
__Other(Specify_____

This authorization will remain in effect until: _____
Date

THIS AUTHORIZATION WILL BE EFFECTIVE FOR MEDICAL RECORDS GENERATED TO THE DATE OF SIGNATURE.

I UNDERSTAND I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY PROVIDING MY WRITTEN REVOCATION.

_____ _____
Signature of Patient Date
(If signed by person other than patient, state relationship to patient)

Patient is: ____Minor ____Incompetent ____ Deceased
Legal Authority: ____Parent or Legal Guardian ____ Next of Kin of Deceased ____Power of Attorney for Healthcare
____Legal Authorized Representative ____Executor of Estate of Deceased

This release is executed in conformity with Wis. Stats. §§ 146.81-.83, 51.30, 252.15