AUTHORIZATION TO RELEASE DENTAL RECORDS AND X-RAYS

I hereby authorize Sanitas Dental of South Florida PA to release my dental records, including treatment notes, x-rays, images, and any other related documents, to the following office or individual:

Name of Office/Provider/Individual: _____

Address/Email/Fax: _____

Phone Number: _____

Purpose of Release (check one):

☐ Continuation of care

☐ Insurance purposes

☐ Personal request

☐ Other: _____

I understand that:

- This authorization allows Sanitas Dental of South Florida to release copies of my dental records and x-rays as indicated above.

- I may revoke this authorization in writing at any time, except to the extent that records have already been released.

- Sanitas Dental of South Florida is not responsible for how the recipient uses or discloses my records once released.

Patient Information:

Patient Name: _____

Date of Birth: _____

Phone Number: _____

Patient/Guardian Signature: _____

Date: _____