

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name: _____ Date: _____

Patient Telephone: _____ Patient Email: _____ DOB: _____

PLEASE SELECT THE APPROPRIATE REQUEST AND SIGN BELOW:

- I authorize the release of my complete medical and/or dental records **TO** Dr. Kari Mann. I acknowledge that information release may include health history, X-rays, diagnosis and treatment information.

PLEASE PROVIDE X-RAYS IN DIGITAL FORMAT AS INDIVIDUAL UNCOMPRESSED JPEG FILES.

Please securely email information to **contact@karimandentalstudio.com**

-OR-

- I authorize the release of my dental records **FROM** Dr. Kari Mann to _____.
I acknowledge that information release may include health history, X-rays, diagnosis and treatment information. I further assume all responsibility for maintaining the privacy of my records as they are sent using the method I choose.

Email Records to: _____

Hold for Pick-up

Please share with us your reason for requesting your records:

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment. You are specifically authorized to release all medical and/or dental information as requested by the above entity.

Signature of patient or patient's authorized representative

Date Signed

Relationship or status if signed by anyone other than patient (parent, legal guardian, representative, etc.)