

Request for and Authorization to Release Dental Records or Health Information

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Moorhead, MN 56560
218-236-1322
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ames & peterson
ORTHODONTICS, PLLC

605 Highway 34 E
Detroit Lakes, MN 56501
218-847-3372
(fax) 218-847-5995

I request and authorize release of information as specified below to the organization or individual named on this request. (Please complete all portions.)

Patient's Info: First Name: _____ MI: _____ Last: _____ Birth Date: _____

Patient ID#: _____ Contact phone for any questions about this release: _____

FROM:

Records held by (please check one):

☐ Ames and Peterson Orthodontics, PLLC

[or]

☐ Name: _____

Address: _____



TO:

To be released to (please check one):

☐ Name: _____

Address: _____

[or]

☐ Ames and Peterson Orthodontics, PLLC

Please release:

☐ Complete clinical, financial and lab records held by this office.

☐ Appointment Reminders to the following mobile number (texts) and/or email address (emails): _____

☐ A specific portion of the patient record. Please specify: _____

Reason for request:

☐ Coordinate care with another provider

☐ Patient is an adult (≥ 18) and authorizes our team to discuss or share specified protected health information with the specified parent/guardian(s). (Exceptions where authorization is not required include discussing billing with the party who signed an ongoing contract for patient's treatment or discussing insurance with the policy holder.)

☐ Personal records

☐ Transferring out of practice. If so, are you:

☐ Moving

☐ Other. Please specify: _____

☐ Other. Please specify: _____

Signature: Is Patient 18 Years Old or Older?

☐ YES: Patient Signature: _____ Date: _____

☐ NO: Signature of Legal Guardian: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____