Lakeside Dental Care

2400 Veterans Blvd., Suite 210
Kenner, Louisiana 70062
Phone: 504-833-3200 Fax: 504-833-0813

1000 C. M. Fagan Drive, Suite A
Hammond, LA 70403
Phone: 985-345-4166 Fax: 985-345-4213

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

Patient Name: _____ SSN: _____

Address: _____

Forward the records to: _____
Name

_____
Address

_____
City State Zip

Purpose of Sending Records – Please Mark All Appropriate Reasons

There will be a minimal fee to comply with your request! Once the fee is paid the records will be released.

Referral _____ Patient Copy _____ Attorney _____

Changing Dentist _____ Name of New Dentist _____

Other _____ Moving Out of Area _____

Insurance Change _____ Dissatisfied With Office _____

Location Convenience _____

Specific dates or time period of visits to be copied: _____

********************Indicate the portions of the record to be copied*********************

Exams _____ Treatment Plans _____ Xrays _____ Consultations _____

I understand that I may revoke this consent, in writing, at any time, and that in any event, it will expire 60 days from this date, unless sooner revoked, and that upon the fulfillment of the above stated purpose this consent will automatically expire without my express revocation. Records will be available/mailed within 10 working days.

_____ _____

Authorized Signature Date Witness Date