LAKESIDE DENTAL CARE

2400 Veterans Blvd., Suite 210
Kenner, Louisiana 70062
(504) 833-3200
FAX (504) 833-0813

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