AUTHORIZATION TO RELEASE INFORMATION

(The execution of this form does not authorize the release of information other than that described below)

Patient Name: _____ Drs. Name: _____

DOB: _____ Address: _____

_____

Phone Number: _____

I request and authorize the above-named doctor to release the information specified below to:

Doyle Freano, Jr.
2353 Alexandria Drive Suite 300
Lexington, KY 40504
859-296-9711

Information Requested

❑Copy of complete dental chart
❑Copy of dental x-rays
❑Limited to treatment dates and for the condition as described: _____

❑Other (i.e. models, Dr. correspondence, etc.) Please, describe: _____

Purpose for which the information is to be used:

❑Transfer of records ❑Second Opinion

❑Other Please, describe: _____

I certify that this request was made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent action has been taken to comply with my request. Without my expressed revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event:

❑On _____(date)
❑Revoked in writing
❑180 days from the date of this authorization
❑Under the following condition: Please, describe:_____

A copy of this authorization or my signature ❑may ❑may not be used with the same effectiveness as the original.

Patient Name: _____ _____
Print Person authorized to sign if patient is not 18

_____ _____
Signature Relationship to patient

Date: _____