

# Authorization for the Release of Dental Records

Minnesota

I hereby authorize \_\_\_\_\_, DDS to release the information in the dental record of \_\_\_\_\_ (patient's name) to

\_\_\_\_\_  
(name of dentist, physician, clinic, or patient's representative)

\_\_\_\_\_  
(address)

The purpose of this release of health information is: \_\_\_\_\_

All information regarding any treatment in your office (a) between \_\_\_\_\_ (dates); or (b) related to (name procedure(s) or treatment(s), condition, specific report(s)) \_\_\_\_\_

\_\_\_\_\_ may be released including, but not limited to, mental health records; drug and/or alcohol abuse records, which are protected by state or federal law; or HIV test results and related health care issues, if any, except as specifically provided below.

**Optional:** I understand and agree to pay a reasonable charge to cover the cost of the transfer, as allowed by MN Statute §144.335, Subd. 5. Since the charges change annually, call the Department of Health at (800) 657-3793 or at (651) 282-6314 for the most accurate amount.

This authorization is effective now and will remain in effect until \_\_\_\_\_ (no longer than one year). I understand that I may receive a copy of this authorization before the year is over. I understand that I may receive a copy of this authorization.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If not signed by the patient please indicate relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

***COPY TO BE PLACED IN PATIENT'S CHART***