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