Coastal Bend COLLEGE

AUTHORIZATION TO RELEASE DENTAL INFORMATION

PATIENT NAME: _____ **DOB:** _____

AUTHORIZES: **Coastal Bend College Dental Hygiene Department**
3800 Charco Road Beeville, Texas 78102

TO DISCLOSE TO: ☐ Self ☐ Dental Provider ☐ Other _____
Delivery options: ☐ Mail ☐ Pick up (please fill in below)

To be picked up by, I hereby authorize _____ to pick up my records. (*photo ID required.*) ***OR***
Send to: _____
Name of Health Care Provider/Plan/Other/Myself

Address: _____

Phone: _____ Fax: _____

When transferring information to another dental office we only send current x-rays (bitewing x-rays, full mouth x-rays, and panorex) within the last 5 yrs. and treatment dates for prophy' s (cleanings)-exams-scale & root planing.

Information requested:
_____ Copy of entire record
_____ Copy of dental x-rays
_____ Copy of dentist exam
_____Copy of periodontal charting

Dates covered:
"Limited to treatment dates"
_____

Effective Date of Authorization:
This authorization is effective one year from this date listed below or until I cancel this consent. I understand that I may revoke or terminate this authorization by submitting a request in writing to: Coastal Bend College Dental Hygiene Department 3800 Charco Road Beeville, Texas 78102.

X_____ Date: _____

If signed by a person other than the patient, complete the following:

Individual Is: ☐ Parent or legal guardian ☐ Legally Incompetent ☐ Incapacitated deceased ☐ next of kin/executor of deceased
(legal documentation of authorization must be provided.)

By signing, I understand that the information released per this authorization, if redisclosed by the recipient, is no longer protected by Coastal Bend College Dental Hygiene Department.

Radiographs reviewed/approved by: _____ Date: _____

Administrative Support Specialist: _____ Date: _____

Please forward to Administrative Support Specialist for Processing

Revised 8/24