PARTNERSHIP HEALTH CENTER 406-258-4185-Dental
401 Railroad W, Missoula, MT 59802 406-258-4170-Fax
Dental@phc.missoula.mt.us

AUTHORIZATION TO RELEASE DENTAL INFORMATION

____ ______________________
Patient's Last Name First MI Date of Birth

____ ______________________
Any other name known by Social Security Number

____
Patient's Mailing Address

____ ______________________
City State Zip Phone Number

I WANT PHC TO GET MY RECORDS FROM The following provider and therefore I authorize them to release records to PHC:

____
Provider's Name

____
Dental Facility Name or Address

____
City State Zip

______________ ______________
Telephone Number Fax Number

I WANT PHC TO SEND MY RECORDS TO The following provider and I authorize PHC to release records to:

____
Provider's Name

____
Dental Facility Name or Address

____
City State Zip

______________ ______________
Telephone Number Fax Number

____
Provider e-mail

I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes information regarding the following conditions(s):

INFORMATION REQUESTED:

Copy of dental x-rays

My dental records for the following dates:
____

Entire dental record

Include Exclude: My health information related to drug and/or alcohol abuse

Include Exclude: My health information related to HIV/AIDS

Most recent ______ years of record

Other Information (describe information in detail)____
____

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:

Treatment Second Opinion

To the following Family Members: ____

Other, (describe the purpose of the requested use and disclosure in detail): ______________________________
____

AUTHORIZATION: I authorize the release of my confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions.
I understand that this authorization may be revoked by me at any time, provided that I do so in writing, up to the extent that the disclosure has not already been made. The revocation is effective from the time it is communicated to the health care provider. If not revoked, this authorization expires in six (6) months from the date of signature unless otherwise specified.
(MCA 50-16-527)

______________________________ ______________________________ ____________
Patient Name (print) Patient Signature Date

______________________________ ______________________________
Signature of Patient's Authorized Representative Relationship to Patient if Personal Representative