Authorization for the Release of Dental Records

Date: _____

I hereby authorize: _____ to release the information in the dental records of:

_____

Patients' name

To:
Rodica Grasu, DDS, MS
818-990-5090

Email to: ***office@perio-dental-implants.com***
I recognize that email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties.

Or:

Mail to: Dr. Rodica Grasu, DDS, MS
16055 Ventura Blvd., Suite 405, Encino, CA 91436

Any and all information may be released including, but not limited to x-rays, photos, intra oral pictures, and clinical notes.

This authorization is effective now and will remain in effect until _____ (date)

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