DR. KEVIN RUSSELO
& ASSOCIATES

AUTHORIZATION TO RELEASE DENTAL INFORMATION

The execution of this form does not authorize the release of information other than the terms specifically described below

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TO: _____

PHONE: _____**FAX:** _____**EMAIL:**_____

PATIENT NAME: _____ **D.O.B:** _____

RELEASE TO: DR. KEVIN RUSSELO & ASSOCIATES

FAX: 416 323 0283

PHONE: 416 966 0117

I requested 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 condition(s):

INFORMATION REQUESTED:

- ☐ Copy of recent dental chart
- ☐ Copy of dental x-rays Date: _____
- ☐ All treatment rendered
- ☐ Others: _____

*****PLEASE EMAIL ALL DIGITAL X-RAYS TO DENTALOFFICE@DRRUSSELO.COM*****

PURPOSE FOR WHICH INFORMATION IS TO BE USED:

- ☐ Transfer of Records
- ☐ Second Opinion
- ☐ Others, please explain: _____

AUTHORIZATION: *I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken to comply with it. With my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure.*

_____ _____

Signature **Date**