

Cook Area Health Services, Inc. dba Scenic Rivers Health Services  
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Cook, MN 55723  
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**AUTHORIZATION TO RELEASE DENTAL INFORMATION**

(The execution of this form does not authorize the release of information other than the terms specifically Described below.)

Patient Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Home Address: \_\_\_\_\_

**This will Authorize:**

Name/Organization: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Email address: \_\_\_\_\_

\_\_\_\_\_ **TO RELEASE RECORDS TO** \_\_\_\_\_ **TO REQUEST RECORDS FROM**

Name/Organization: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Email address: \_\_\_\_\_

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 condition(s):

**INFORMATION REQUEST** \_\_\_\_\_ **DATES COVERED:** \_\_\_\_\_

\*Limited to treatment dates and for  
\_\_\_\_\_ Copy of complete dental chart condition described below:  
\_\_\_\_\_ Copy of dental x-rays  
\_\_\_\_\_ All treatment rendered \_\_\_\_\_  
\_\_\_\_\_ Others (e.g. models—describe) \_\_\_\_\_

**PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:**

\_\_\_\_\_ Transfer of Records \_\_\_\_\_ Second Opinion  
\_\_\_\_\_ Other, please explain \_\_\_\_\_

*This authorization will automatically expire one year from the date of my signature or \_\_\_\_\_ (period of time, for example 2 days, or 3 weeks, or 5 months) from the date of my signature, if specified here. The expiration period noted here may exceed one year in certain situations as specified in Minnesota statute 144.335 3a; for release to a provider in connection with current treatment; for release for purposes of payment of claims, fraud investigation or quality of care; for release to an external researcher solely for purposes of medical or scientific research. As noted above, I understand I may revoke this authorization by written request at any time to the address listed above.*

*I understand there may be a retrieval and copy charge associated with the release.*

*I understand that once information is released pursuant to this authorization, Cook Area Health Services, Inc. cannot prevent the re-disclosure of the information to another third party.*

*I understand this authorization must be filled out completely, signed, and dated in order to be considered valid. A fax or photocopy that has not been altered will be considered as a valid as an original.*

\_\_\_\_\_  
Signature of Patient/Authorized person \_\_\_\_\_ Date

\_\_\_\_\_  
Authorized Person's Authority to Sign (Parent, Guardian, Power of Attorney, ECT.) Copy of Power Attorney must be on Record to release/request health information  
Reason Patient is Unable to sign: \_\_\_\_\_ Minor \_\_\_\_\_ Deceased \_\_\_\_\_ other: \_\_\_\_\_