Cook Area Health Services, Inc. dba Scenic Rivers Health Services
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Tower, MN 55790
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Towerdental@scenicrivershealth.org

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 statue 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: _____

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