PARTNERSHIP HEALTH CENTER 406-258-4185-Dental
401 W Railroad, 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