1136 N. Muldoon Rd Suite 110
Anchorage, AK 99504
Tel: (907) 333-6666 Fax: (907) 333-3390
btydentalgroup@gmail.com

Today's Date: _____
Patients Full Legal Name:_____
Patients Date of Birth: _____
Patients Current Address: _____
Phone: _____

Patient is Reqeusting: Records and Xrays _____ Xrays Only_____ Records Only_____
Records to be: Emailed_____ Picked up in Office_____ Faxed_____ Mailed_____
Mailing/Email address/Fax #:_____
I authorize _____ to release my records and give permission for the following company/person to receive disclosure of protected health information about me:

Myself_____

Name: _____ Phone:_____
Fax: _____ Address: _____
_____

Reason for request:
Referred out: _____ Moving:_____ Other:_____ (Explain)_____
_____

Once all records are forwarded to the requesting person/facility, bty DENTAL can not be held responsible for any intentions or use of those records.

I may revoke this authorization at any time by notifying bty DENTAL l in writing. However, any previous actions that have already been taken upon this request cannot be reversed.

This authorization expires on _____, 20_____.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

_____
Signature of Patient

_____
Signature of Guardian or personal representative **Relationship to Patient**

A copy of this completed, signed and dated form must be given to the Individual.

Office Use Only

_____ _____
Received By: Processed By:

_____ _____
Date Received: Date Processed: