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AUTHORIZATION FOR RELEASE OF INFORMATION

I, ---------- DOB:----------hereby request
(Patient's name)

_---------- ----------
(Name of person providing records) (Address)

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(City) (State) (Zip) (Phone) (Fax)

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to provide Studio G Aesthetic and Family Dentistry with a copy of the following records:

X complete dental radiographs **X complete dental chart Notes**

- **I understand that this authorization is voluntary.**
- **I understand that the released information may no longer be protected by federal privacy regulations once it is released.**
- **The purpose of this disclosure is: per patient request**
- **Neither Studio G nor the person receiving the above information will be receiving financial or in-kind compensation in exchange for using or disclosing the health information described above.**
- **I understand that my health care and the payment for my health care will not be affected if I do not sign this form.**
- **I understand that, upon my request, I may see and copy the information described on this form, with the exception of:**

- **I may also receive a copy of this form after I sign it.**
- **I understand that this authorization will expire one year from the date of the signing of this form.**
- **I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any effect on any actions the organization took before it received the revocation.**
- **I agree that a copy of this form has the same effect as the original.**

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Signature of patient or patient's representative: Date:

Printed name of patient's representative and Relationship to patient:

**** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ****

To providing Office : If possible Please email Chart Notes as .pdf and X-rays as .jpg