LAKE DISTRICT
FAMILY DENTISTRY
CARLTON, RICHTER & MANGUM

Request for the Release of Patient Records

Patient Name: ____

Birthdate: ____

Address: ____

____

Telephone: ____

I authorize ____ **to release my records to the Doctors of Lake District Family Dentistry.**

Information requested:

- ☐ Dental/ Medical Records
- ☐ Patient Report(s) prepared from this office
- ☐ Test Results
- ☐ X-Rays
- ☐ Polysomnography/ Home Sleep Test

Records are needed for:

- ☐ Coordinating Care of Oral Appliance Therapy for Obstructive Sleep Apnea
- ☐ Insurance
- ☐ Communication with your other Health Care Providers
- ☐ Legal Purposes
- ☐ Continuing Care
- ☐ Other ____________________________

I understand that the information to be released may include history, diagnoses, and or treatment of therapy related to this dental office. I also understand that this authorization may be revoked by the person giving authorization by a written and dated notice, except to the extent that disclosure of information has been made prior to receipt of the revocation. This authorization will expire 90 days from the date of signature. I have read and understand this consent and I have signed it voluntarily and of my own free will.

SIGNATURE OF PATIENT OR GUARDIAN:

____ DATE:__________________________

Please complete and FAX or Email. Thank you.

FAX: 318-473-8289

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Changing Lives One Smile at a Time…