Authorization to Request Dental Records

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Patient's Name: ____________________________ DOB: __________ Telephone: ______________

Mailing Address: ___________________________ City/ State/ Zip: _____________________________

Email *(**encrypted** & will expire after 7days of opening)*: _______________________________

Dental Clinic Email: **mmendoza@avhc.org**

I specifically authorize release of the following information:

- X-Rays
- Other Images

Notes:

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- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: **Anderson Valley Health Center @ 13500 Airport Rd. Boonville, Ca. 95415**
- My revocation will take effect upon receipt, except to the extent those others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.

Patient or Authorized Representative of the Patient:

Signed: ___________________________________ Print Name: ________________________________

Relationship to Patient:____________________ Date: _______________________

*** FOR OFFICE USE ONLY ***

☐ REQUEST COMPLETED:

- DATE: ______________
- STAFF INITIALS: ________
- #PAGES: ________

☐ IDENTITY OF INDIVIDUAL AND/OR LEGAL REPRESENTITIVE VERIFIED:

STAFF INITIALS: ________

Dental Health

At Anderson Valley Health Center

13500 Airport Rd. Boonville, Ca. 95415 or PO Box 338 Boonville, Ca. 95415

Telephone: (707) 895-3477 or Fax: (707) 895-2035