Tummarello &Pandak, DDS
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AUTHORIZATION TO RELEASE DENTAL/Medical RECORDS

Patient Name ____________________Contact Phone Number____________

Patient Date of Birth______________

Patient Address ____

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At the request of the individual, I (patients name) ______________________________do hereby authorize **The Office of Tummarello & Pandak, DDS** to release dental/medical information concerning my medical/dental treatment to the party listed below:

INFORMATION RELEASE TO:

Name ____
Street Address ____
City/State/Zip ____
Phone# ___________________________________Fax# _________________________

Reason for Disclosure:

- Transfer of Care
- Moved
- Insurance
- Other

I understand my records are protected under Federal Confidentiality Regulations and under the General Laws of the State of Virginia and will not be disclosed without my written consent, except as otherwise specifically provided by law.

Any information to be released is authorized by this consent, and shall not be given, transferred, or relayed in any manner to any other person, other than stated above.

I understand that there may be a charge as allowed under Virginia Statute.

Signature of Patient/Representative or Guardian ___________________________________

Date (authorization will expire 12 months from date signed) _________________________