DR. MICHAEL P. MORIARTY, P.C.
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CONSENT FORM FOR RELEASE OF PATIENT INFORMATION

I, ___________________________, and any other listed dependent family members, give permission to release copies of my (our) dental records, for the purpose of patient care,

NAME: _________________________________BIRTHDATE:____________________
NAME: _________________________________BIRTHDATE:____________________
NAME: _________________________________BIRTHDATE:____________________

☐ Name/Address of organization or individual ☐ RELEASING ☐ RECEIVING information:

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EMAIL ____
PHONE NO: _______________________ FAX NO _____________________

INFORMATION TO BE DISCLOSED:

- ☐ Clinical and Periodontal Chart
- ☐ x-rays, ***digital preferred,*** **no older than 1 year (please do not send originals)**
- ☐ Pano, ***digital preferred,*** **no older than 5 years (please do not send originals)**
- ☐ Other ____ (*may include fees*)

I understand that:

1. This authorization is voluntary.
2. I have the right to request a copy of this form.
3. I may revoke this authorization at any time by notifying Dr. Michael P. Moriarty *in writing.* However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon.
4. If the person or organization authorized to receive the information is not a health plan, health care clearinghouse, or health care provider, the released information may no longer be protected by federal privacy regulations.
5. If I am requesting the records for myself, I will be given a *copy* of my records. The original records remain the property of Dr. Michael P. Moriarty.

I understand that the information disclosed will include my dental health information. This authorization will expire 180 days from the signature date.

_____________________________ _____________________ _____________
Print Name of Patient **Social Security Number** **Date of Birth**

_____________________________ _____________
Signature of Patient or Parent/Guardian **Today's Date**

*************************************OFFICE USE ONLY** ***

Date patient requests records ________________ Date sent/ by whom ________________
Sent to: ____
Additional Notes:
____