Lisa Henson, DMD
Steven Mahler, DDS
Casey Newton, DDS
Randal Shook, DDS
1102 Regis Court Eau Claire WI 54701
regiscourtdental.com 715.834.2032

# Records Release Form

I, ........................................................................................................ hereby authorize
**PATIENT'S NAME and DATE OF BIRTH**

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**PREVIOUS DENTIST'S NAME**

to provide ..............................................................................................
**PARTY TO WHOM THE RECORDS WILL BE SENT**

with copies of my dental records with respect to any dental care and treatment.

I understand that the specific type of information to be disclosed includes a detailed report of examinations, findings, treatments, prognosis and copies of any and all other records, including x-rays, which pertain to me.

This consent is voluntary. We will not condition your treatment on receiving this consent. Not everyone is subject to federal rules protecting patient privacy, and it is possible that your information may be disclosed to someone who is not subject to these rules, so that your information may no longer be protected by federal rules protecting your privacy. For example, we may need to disclose your dental information to another health care provider who is not subject to federal privacy rules because they do not bill electronically, or a health plan that we disclose your information to so they can pay your bill may redisclose your information to an accreditation or regulatory agency that is not subject to federal privacy rules.

This consent is effective for one year from the date signed unless I cancel this consent in writing delivered to the dentist's office listed above. Cancelation of this consent will not affect any action taken in reliance on this consent before we received your written notice of cancelation.

Signed ..................................................................... | ..............................................................................

PATIENT | PARENT, LEGAL GUARDIAN, OR CUSTODIAN OF THE PATIENT IF THE PATIENT IS LESS THAN 18 YEARS OLD

Address ..............................................................................................................................
STREET

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CITY STATE ZIP

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DATE SIGNED