TAO GAO DDS PA
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AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

To request release of dental information, please complete and sign below.

Patient Name: _____ Date of Birth:____/____/____

I hereby voluntarily authorize _____ the disclosure of information from health record.

The information is to be released to:

Name of person/Organization/Facility:_____

Email: _____

Information requested:_____

_____

I understand that this authorization will EXPIRE on _____.
I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying RTP DENTAL CARE in writing.
I understand that RTP Dental Care, by releasing authorized information, is hereby relieved from all legal responsibility or liability for the release of the information described above to the extent indicated and authorized herein.

_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient