833 Lane Allen Road Lexington, KY 40504
(859)277-1189

Authorization to Release Health Care Information

Patient Name:_____ **Date:**_____

Patient ID#_____ **DOB**_____

I request and authorize _____ to release/receive health care information for the patient named above to/from Garden Springs Dental, the office of Dr. Christopher S Davis, DMD and Dr. Greg Edens, Jr, DMD.

This request and authorization applies to health information relating to the following treatment, condition or dates:

☐ Bitewing x-rays _____

☐ Full mouth series _____

☐ Panoramic x-rays _____

☐ Perio charting _____

Treatment notes regarding: _____

_____

_____

We would prefer digital records sent by email if possible.

Please email to: kentuckydentist@gmail.com

If email not available please fax requested records to (859) 276-2719.

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure; 180 days from the date hereof; or under the following conditions:

List of conditions: _____

_____ _____

Patient's Signature Date

_____ _____

Signature of Guardian (if patient is a minor) Date