AUTHORIZATION FOR RELEASE OF ENDODONTIC RECORDS

Per Endodontic Associates HIPPA privacy policies, I authorize the release of my endodontic treatment record, reports, digital imaging and/or pre-operative/post-operative x-rays as follows:

Please print:
Patient Name:_____

Date of Birth:_____

Address:_____
City:_____ State:_____ Zip:_____

Phone:_____

AUTHORIZATION: I request and authorize Endodontic Associates to release to me the information specified above. I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I release the above named dentists and/or practice from liability and claims of any nature pertaining to the disclosure of requested information contained in my dental records.

Patient Signature:_____
Date:_____

Please mail the **completed form** and **$55** records retrieval fee to:

Endodontic Associates Drs. Joel and Judy Jose
102 W. Main Street
P. O Box 609
New Albany, Ohio 43054

The above endodontic records have already been shared with your referring dentist/primary general dentist and should already be included in your main chart at their office.