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California Authorization for the Release of Dental Records

I hereby authorize _____, DDS to release the information in the dental record of
(Dentist's Name)

(Patient's Name)

to _____
(Name of Dentist, Physician, Clinic,
or Patient's Representative)

(Address and Email)

[I understand and agree to pay a reasonable charge to cover the cost of transfer, as allowed in the Health and Safety Code §5123100
et seq and Evidence Code §1158]

This authorization is effective now and will remain in effect until indefinitely/_____
(date)

I understand that I may receive a copy of this authorization.

Signed: _____

Date: _____

If not signed by the patient, please indicate relationship:

- Parent or Guardian of minor patient
- Guardian or Conservator of an incompetent patient
- Beneficiary or Personal Representative of deceased patient

COPY TO BE PLACED IN PATIENT'S CHART

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