**RECORDS RELEASE REQUEST**

I authorize the release of dental records and medical records relevant to dental treatment, or copies of such to include: Progress notes, Periodontal Charting, Hard/Soft Tissue Exams, Unfinished Treatment Plan and X-rays, and request that they be transferred.

I understand the purpose of the use and/or disclosure is for further treatment, insurance purposes, legal or personal records. I understand the information used and/or disclosed may no longer be protected by HIPAA and the recipient may potentially re-disclose it. I understand that I may revoke this authorization at any time by notifying both parties in writing. The statements made in this authorization are binding.

TO:

**LAKERIDGE DENTAL**

**Riewer & Manke, DDS**

**PO Box 517**

**Detroit Lakes, MN 56502**

**218-847-9214 fax 218-847-9215**

**lakeridge4accounting@live.com**

 FROM:

Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ St. \_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_

Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number of patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth of patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Parent if a minor