California authorization for the release of dental records

I hereby authorize _____ DDS to release

the information in the dental record of _____
(Patient's name)

to _____
(Name of dentist, physician clinic, or patient's representative)

_____
(Address) (City/state/zip)

Any and all information may be released including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV tests, if any, except as specifically provided below.

_____

I understand I may receive a copy of this authorization.

Signed :_____ Date: _____
(Patient, guardian or beneficiary)

_____

Enclosed:

_____ Last full-mouth series

_____ Last Bite-wing series

_____ Last Panoramic Film

_____ Last periodontal probing record

Last seen in our office: _____

Last Prophylaxis: _____

Reason for leaving practice: _____