Donald M. Hanson, DDS
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(317)-721-1552 Fax (317)-663-8569

Authorization to Release Dental Records

Patient Name:_____**Date of Birth**: ___/___/____

Address:_____

Patient Ph. #:_____

I,_____hereby authorize

_____
Previous DDS

To provide **Hanson Family Dentistry, LLC** with copies of my dental records with respect to any dental care and treatment that I have received. Records to be provided should include, but not limited to, the following information:

(1) Patient chart history for the past seven (7) years
(2) Patient treatment planned but not yet completed for the past two (2) years
(3) Periodontal charting for the past two (2) years
(4) Bitewing cavity detection x-rays for the past two (2) years
(5) Panolipse of Full Mouth Series x-rays for the past five (5) years

I understand that the specific type of information to be disclosed includes a detailed report of examinations, treatment provided, x-rays and all other records which pertain to me.

I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Please forward to: Hanson Family Dentistry
61 E. 96th. Street
Indianapolis, IN. 46240

Email: office@donaldhansondds.com

Signature:_____**Date:**___/___/____
Patient, Legal Guardian or POA of patient