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**Authorization to Release Health Care Information**

In accordance with Tennessee State Law T.C.A.63-2-101(a)(10) that states “a copy of the patients dental records must be released to the patient or the patient’s authorized representative within 10 days upon request in writing.”

Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request and authorize:

Doctor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_

Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To release health care information of the patient named above to:

Klein Dental Arts

1905 West Broadway

Maryville, TN 37801

Phone (865) 983-0941 Fax (865) 984-4756

Info.kleindentalarts@gmail.com

This request and authorization applies to dental x-rays and any requested patient records, belonging to the above named patient. Please e-mail x-rays to: Info.kleindentalarts@gmail.com

Thank You,

I understand that my express written consent is required to release any healthcare information relating to testing, diagnosis, and treatment.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Guardian (Please Print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Patient or Guardian