DR. MATTHEW **RYAN**

AUTHORIZATION FOR THE RELEASE OF DENTAL RECORDS

I hereby authorize ____
Previous Dental Practice

to release the information in the dental record of ____to:
Patient Name

4350 Marconi Ave., Suite. 100
Sacramento, CA 95821
916.486.8255

or, email securely to: info@drryandds.com

Please do not provide photocopies of radiographs. Please send digital images electronically. Mail duplicate films, when applicable. If you require a USB drive for large digital files (like cone-beam CT), we can provide one.

All information may be released except as specifically provided below:

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This authorization is effective now and will remain in effect until revoked by me or my representative.

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

Signature____ 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

NOTE: This authorization is intended to comply with applicable state laws. It is not intended as a "Consent" or "Authorization" for the use and disclosure of Protected Health Information (PHI) under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or its implementing regulations. The medical provider to whom this authorization is directed should ensure that he or she is in compliance with applicable HIPAA requirements before releasing the requested records.