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**Authorization For The Release Of Dental Records**

*California*

I hereby authorize \_\_\_\_\_, D.D.S. to release the information in the dental record of  
 \_\_\_\_\_ (Patient's name) to

\_\_\_\_\_  
 (Name Of Dentist, Physician, Clinic, Or Patient's Representative)

\_\_\_\_\_  
 (Address)

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 test results, if any, except as specifically  
 provided below.

\_\_\_\_\_  
 [Optional: I understand and agree to pay a reasonable charge to cover the cost of the transfer, as allowed in Health  
 and Safety Code §123100 *et seq.* and Evidence Code §1158.]

This authorization is effective now and will remain effective until \_\_\_\_\_ (date).  
 I understand that I may receive a copy of this authorization.

\_\_\_\_\_  
 Signature

- 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.

**CAUTION:** If you intend to use the requested information for any purpose other than providing medical treatment,  
 45 CFR Section 164.502 requires that you make reasonable efforts to limit your request for PHI to the minimum  
 necessary to accomplish the intended purpose of the request.

To be valid, an authorization must be clearly separate from other language on a page and executed by a signature  
 which serves no purpose other than to execute the authorization. It can either be handwritten by the person who  
 signs it or in typeface no smaller than 8 point (this is 8 point).

**COPY TO BE PLACED IN PATIENT'S CHART**