ORTHODONTICS of ATLANTA
Your Smile is our Specialty!

ORTHODONTICS RECORDS RELEASE FORM

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

AUTHORIZES: **ORTHODONTICS OF ATLTANTA**
1568 Indian Trail Rd. 201. Norcross. GA 30093 || 1670 McKendree Church Rd. 700. Lawrenceville. GA 30043

TO DISCLOSE TO: ☐ Self ☐ Dental Provider ☐ Other _____

Delivery options ☐ Regular mail (+$5.00) ☐ email ☐ fax ☐ pick up *(please fill in below)*

To be picked up by, I hereby authorize _____ to pick up my records. (Photo ID required.)

Send to: _____
Name of Health Care Provider / Plan / Other/ Myself

_____
Address

PHONE: _____ FAX # _____

EMAIL : _____

Only information from the past five (5) years will be disclosed.
When transferring information to another dental/orthodontics office we only send current x-rays within the last 5 yrs. To send just this basic information described above please check here ☐
If you want us to release other information, then please mark below.
INFORMATION TO BE DISCLOSED:
Treatment plan ☐ Radiology films/images ☐ All billing records ☐

Specific records/information as follows: _____

_____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED:

_____
EXPIRATION: This Authorization is good for one year.
SIGNATURE OF PATIENT / LEGAL REP:

_____DATE: _____
If signed by a person other than the patient, complete the following: Individual is: ☐ parent* legal guardian
☐ legally incompetent ☐ incapacitated deceased ☐ next of kin / executor of deceased

By signing, I understand that the information released per this authorization, if redisclosed by the recipient, is no longer protected by Vinh P. Huynh, DMD, MS, PC (dba: Orthodontics of Atlanta).