Wilson Dental, PC
289 Chenango St
Binghamton, NY 13901
P: 607-217-7123
F: 607-238-1276

Wilson Dental, PC
2028 Dryden Rd
Freeville, NY 13068
P: 607-844-3455
F: 607-844-4761

Wilson Dental, PC
728 E Ridge Rd
Rochester, NY 14621
P: 585-491-7800
F: 585-491-7796

Wilson Dental, PC
224 S Geddes St
Syracuse, NY 13204
P: 315-423-9900
F: 315423-9901

Wilson Dental, PC
463 Fulton St
Waverly, NY 14892
P: 607-565-4374
F: 607-565-7438

Authorization for Release of Protected Health Information (PHI)- Dental Record

1. Patient Information

Last Name_____ First Name_____ MI_____

DOB_____ Patient Former Name (if any) _____

Address _____ City_____ State_____ Zip _____

Home Phone_____ Cell Phone_____

Work Phone_____ Email_____

2. Recipient Authorization

I, _____, do herby authorize _____ to release a copy of my dental records to the person or facility below.

Name of person or Facility receiving dental records _____

Address _____ City_____ State_____ Zip_____

Phone_____ Office Email_____

3. Information to be Released

☐ **Entire dental records** ☐ **Full mouth series (FMX)** ☐ **Panoramic X-ray** ☐ **Bite wings**

☐ **Individual X-ray #:** ☐ **Treatment Plan** ☐ **Doctors notes**

4. Purpose of Information Release

☐ **Further dental care** ☐ **Payment of insurance claim** ☐ **Legal investigation** ☐ **School records**

☐ **At the request of the individual** ☐ **Preauthorization info** ☐ **Other (specify)_____**

5. Signature of Patient (or Personal Representative)

Signature_____ Date _____

Print Name _____ Date_____

If signed by anyone other than the patient, state the relationship to patient and/or reason and legal authority for signing:

Patient is: ☐ **Under age** ☐ **Disabled** ☐ **Deceased**

Legal Authority: ☐ **Parent** ☐ **Legal Guardian** ☐ **Next of Kin (if deceased)**