Stacey L. Gividen, DDS – Justin D. Simmons DDS
710 North 1st Street – Hamilton, MT 59840
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Records Release Authorization

Patient Name: _____ DOB:_____

I request the names doctor or health care provider to release the information specified below to the organization, agency, or individual names in this request. I understand that the information to be released may include information regarding drug abuse, alcoholism/alcohol abuse, psychological or psychiatric condition if any.

☐ Release dental records **TO** Canyon View Dental from:

Dentist name: _____

Phone #: _____

Fax #: _____

Please email records to hello@canyonviewdental.com or fax to (406)375-1193

☐ Release dental records **FROM** Canyon View Dental To:

Dentist name: _____

Phone #: _____

Fax #: _____

Email: _____

Information to be released:

_____ Current X-rays taken within the last 12 months and any panoramic/full mouth series taken within the last 5 years

_____ Last periodontal charting and notations

_____ Other: _____

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure.

Patient Signature _____ Date _____

Witness _____ Date _____