SR
SMILE RESTORATIONS

RYAN M. JOUETT, D.D.S.

AUTHORIZATION TO RELEASE DENTAL INFORMATION

The execution of this form does not authorize the release of information other than that specifically described below.

To: _____

Patient:_____

Date of Birth: _____ **SSN:** _____

Release To _Ryan Jouett, D.D.S.

I request and authorize the above named doctor or health care provider to release the information specified below to the organization, agency, or individual named in this request. I understand that the information to be released includes information regarding the following condition(s):

Information requested:

_____ Narrative Summary of Treatment : Dates _____
_____ Copy of Complete dental chart
_____ Copy of dental radiographs
_____ Other (models,etc..) describe:_____

Purpose or need for which information is to be used:

_____ Insurance Company Request
_____ Transfer of records
_____ Second Opinion
_____ 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, or 180 days from the date hereof; or under the following conditions:

List conditions: _____
Other conditions: A copy of this authorization, or my signature thereon may _____
may not _____ be used with the same effectiveness as an original.

Signature _____ Date _____

1615 BARAK LN, STE. 5
BRYAN, TEXAS 77802
bvsmilerestorations.com
979-846-1121