Release of Records

Patient Name: _____ DOB: ~~Concerning~~

my right to confidentiality, I hereby authorize copies of the following records and radiographs to be released ☐ **TO:** ☐

FROM:

Dentist/Office Name: _____

Address: _____

Phone: _____ Email: _____

☒ **TO:** ☐ **FROM:**

Dr Andrew Mancin

8675 College Blvd #150

Overland Park, KS 66210

Phone: 913-346-3600

Fax: 913-346-3601

Email: KS01OM@renewyoursmile.com

INFORMATION TO BE RELEASED:

☐ All records ☐ All radiographs

☒ Other: Last 3 office visit notes, Last 3 labs, Any EKG, ECHO 2022-Present

INFORMATION NOT TO BE RELEASED:

_____

_____

Medical Records, without personal identifiers, may be used for a research study

I understand that I may revoke this consent to release of information at any time. However I also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constiture a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization to release information shall expire:

_____
(1 YEAR FROM TODAY'S DATE)

Patient Signature: _____ Date: _____