

RELEASE OF INFORMATION/RECORDS AUTHORIZATION

I, _____, do hereby authorize any dentist, physician or other healthcare provider, clinic, custodian of medical or dental records, laboratory, insurance company, governmental agency, dependents, or who has records pertaining to same relating to dental procedures to furnish to the Oklahoma Board of Dentistry or any of its authorized agents or employees presenting this Release to them, any oral or written statements, x-rays, forms or any records whatsoever with respect to any dental-related history, consultation, condition, prescription, treatment or payment of any dental claim.

I further authorize any of the above persons to make available to the Oklahoma Board of Dentistry, its authorized agent or employee, copies of any information possessed or maintained by them.

An exact copy of this authorization shall be accepted the same as the original in all instances.

Date: _____ Complainant/Responsible Party

Name and Address of Patient: _____

DOB: _____ Telephone: _____

Notary:	
State of _____)
County of _____)
Subscribed and sworn before me this _____ day of _____, 20__.	
Notary Public: _____	
My Commission Expires: _____	
NOTICE: If a notary is not available, please have this authorization witnessed.	
Witness Name and Address: _____	

_____	_____
Signature	Date

Date Released: _____

Agent: _____

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