Chandni P. Jogani, 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 (current dentist) _____

Patient_____

Date of Birth _____

Release to _____

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):

_____ Drug Abuse, if any

_____ Sickle Cell Anemia, if any

_____ Alcoholism or alcohol abuse, if any

_____ Psychological or psychiatric condition, if any

Information requested:

_____ Copy of Complete dental chart

_____ Copy of dental radiographs

_____ Other (models, etc..) describe:_____

Purpose or need for which information is to be used:

_____ 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, but in any event on _____ if revoked in writing by patient; or 180 days from the date hereof; or _____ under the following conditions

_____

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

Signature _____ Date _____

175 S. El Molino Ave, Suite 6 Pasadena, CA 91101 (626)796-5750 f(626)796-3194 email:pasadena@joganidds.com