Dental Records Medical Authorization Release Form
(for Dental Insurance)

Patient Name

Date of Birth

Patient Address

Phone Number

Name of Dental Provider/Clinic Releasing Information

Provider/Clinic Address

Provider Phone Number

Name of Insurance Company/Recipient

Insurance Company Address

Insurance Company Phone Number

Purpose of Release

Types of Records to be Released

Authorization

I authorize the release of my dental and medical records to the above insurance company for the purposes of dental

insurance claim processing. This authorization is valid for one year from the date signed or until revoked in writing.

Signature of Patient (or Legal Guardian)

Date

Relationship to Patient (if not signed by patient)