AUTHORIZATION TO RELEASE DENTAL INFORMATION

I, _____, having an address of
[Name of Patient]

_____, hereby authorize

_____, having an address of
[Name of Dentist or Insurance Carrier]

_____, or record custodian, attorney and/or representatives, to release to the MISSISSIPPI STATE BOARD OF DENTAL EXAMINERS, Suite 100, 600 East Amite Street, Jackson, Mississippi 39201-2801, copies of any and all of my dental records, including but not limited to, treatment records, medical and dental history records, dental hygiene records, x-rays, operative notes, records of administration of local and general anesthesia, records of intravenous or parenteral conscious sedation, records of the administration and/or dispensation of drugs, medication, anesthetics, including controlled substances, payment records, laboratory prescriptions, insurance forms/claims records, diagnostic/treatment models, or any other document or information pertaining to my treatment as requested by the Mississippi State Board of Dental Examiners.

I further authorize the Mississippi State Board of Dental Examiners to take into its possession and/or copy any and all documents or correspondence as described above. I also agree to execute any other release or authorizations, the execution of which may be required under federal or state law prior to release of any of the documents or information requested. Otherwise, this authorization shall constitute a complete release and authorization for all purposes set forth herein.

The recipient of this notice shall be authorized to rely on a copy of this release, provided the same is certified as being a true and correct copy of the original maintained in the office of the Mississippi State Board of Dental Examiners.

EXECUTED, this the _____ day of _____, 20_____.

_____
[Signature of Patient or Guardian]

PATIENT IDENTIFYING DATA [PLEASE TYPE OR PRINT]:

_____, _____, _____,
[Last Name] [First Name] [Middle Name]

Male

_____, _____, _____,
[Sex] [Birth Date] [Social Security Number]

_____
[Approximate Date of Initial Dental Treatment]

I, LEAH DIANE HOWELL, Executive Director, do hereby certify that the above Authorization to Release Dental Information signed by _____ is a true and correct COPY of the original maintained in the office of the Mississippi State Board of Dental Examiners.

_____
LEAH DIANE HOWELL
Executive Director

Print Form