Michelle Caldwell, DDS

7373 W. Jefferson Ave. Suite 204, Lakewood, CO 80227 - (303) 988-7800

Authorization to Release Patient Information

Name of Patient:____

Date of Birth:____

Patient Address:____

____

I hereby autherize:____

To release my medical and dental information to:

Michelle Caldwell, DDS,PC

3110 S. Wadsworth Blvd, Suite 302

Lakewood, Colorado 80227

Or to:

Name: ____

Address: ____

City, State, Zip Code: ____

The information to be disclosed is:

_____ Medical/Dental Information

_____ Treatment/Progress Notes

_____ Dental X-rays

_____ Other ____

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, or in 180 days from this request. I also understand that the information disclosed pursuant to the authorization may be subject to redisclosure and may no longer be protected by the privacy rule.

Signature of Patient: ____ Date: ____