Silva
Family Dentistry
Center for Dental Implants
and Facial Esthetics
42 Lehner St. Wolfeboro, NH 03894

AUTHROIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I authorize Silva Family Dentistry to Send, Release, and Receive Requested Information to and from:

_____

Doctor/Practice Name: _____

Mailing Address: _____

Phone #: _____ **FAX#:** _____

Email: _____ **(for digital records)**

Patient's Full Name: _____ **Date of Birth:** _____

Mailing Address: _____

City: _____ **State/Zip:** _____ **Contact#: ( )** _____

Patient Signature: _____

Check the type of Information that is being requested for the patient: (OFFICE USE ONLY)

(X) Last date of FMX & or Pano w/ BWX: (X) Last date of BWX:

(X) Please email/send copies to SFD@atlanticbbn.net

Was patient treated for periodontal disease: YES NO

(X) If yes please provide the following the information

Last Date of Perio therapy: Last date of Perio maint. Procedures:

PLEASE PROVIDE ALL COPIES OF PERIO CHARTING WITHIN THE LAST 24 MONTHS.

Any other information requests: YES NO

If yes, please fill in to request other specific information:

_____

_____

_____

WE APPRECIATE YOUR PROMPT RESPONSE FOR THIS RECORDS RELEASE, THANK YOU.