

77 South High Street, 18th Floor
Columbus, Ohio 43215-6135



614/466-2580 • Fax: 614/752-8995
www.dental.ohio.gov

OHIO STATE DENTAL BOARD RELEASE OF INFORMATION

I, _____ do hereby authorize the release of
Parent/Guardian/Patient
information and/or original records concerning _____, specifically
Patient's Name
which relate to medical/dental treatment rendered by any health care provider or facility, either at an office facility or any other hospital and/or healthcare treatment center or facility. I hereby authorize the release of information, the original record, or a color copy of the original records regarding any treatment rendered at any of the aforementioned locations by any practitioner, including, but not limited to: **radiographs (originals or scanned to a CD), insurance claim forms, financial records (computer generated or otherwise), progress notes, treatment plan, photos, models, work authorization forms, prescriptions, correspondence and any other documents related to or involving your care and treatment of the named patient.**

I authorize the release of information and/or records to the **Ohio State Dental Board** or its authorized representative. I release any person, institution, organization, company or hospital from any liability as a result of providing the above-stated information and/or records to the **Ohio State Dental Board**. I further authorize the use of a copy of this release for use in obtaining the above-stated information and/or records.

SIGNED: _____

ADDRESS: _____

PATIENT DATE OF BIRTH: _____ DATE: _____

RETURN THIS FORM TO:

OHIO STATE DENTAL BOARD
77 South High Street, 18th Floor
Columbus, Ohio 43215-6135