Leavitt Family and Cosmetic Dentistry
Casey J. Leavitt DDS, PA
333 West Cedar
Pocatello, ID 83201
Phone: (208) 233-6900
FAX: (208) 233-6909

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize _____(previous dental office) to release all dental records to Dr. Casey Leavitt. Office FAX #_____

Patient Name: _____

Date of Birth: _____

These records consist of:

_____ Digital X-rays (most recent, including Bitewings, Panaoramic, and PA's – please include dates)

_____ Periodontal Chart

_____ Treatment chart (completed and recommended)

I release you from all legal responsibility of liability that may arise from this authorization.

Right to Revoke
I understand that I may cancel this Authorization at any time, but it will not affect any release of information completed before I cancel it.

Expiration Date: This Authorization is valid (please check one box):

- □ For six (6) years after the date it's signed
- □ Until _____ (specify date)

Name_____ Date_____

Signature _____

Witness _____

Note: You have a right to keep a copy of this form after you sign it.