CORNERSTONE DENTAL ASSOCIATES

The Center for Oral Health

Records Release Authorization Form

I, (Date of Birth: / /), hereby authorize the office of, or other necessary parties to release dental x-rays and copies of such as follows: Bitewings and periapical x-rays taken within the last year, panoramic or full mouth series taken within the past 5 years to the following office:

Please email to: **teresa@cornerstonedentists.com** or **nicole@cornerstonedentists.com**

Cornerstone Dental Associates
Lutz-Craver, Karner and Associates
101 Life Enrichment Blvd.
Shelby, NC 28150

Signature of Patient/Parent/Guardian:

PATIENT RIGHTS:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign the authorization and that my treatment will not be conditioned on signing.