PERIODONTAL ASSOCIATES OF LAFAYETTE
David L. Alexander, D.D.S., M.S.D., P.C.
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765-447-9319 800-824-1009 765-447-7227

AUTHORIZATION OF RELEASE OF HEALTH RECORDS

I, ____, would like to have my dental records

transferred to the following entity:

____

____

____

Signature____Date_______________

SENSITIVE HEALTH INFORMATION

(If applicable)

Indiana law requires that individuals expressly authorize the release of mental records or records that reference communicable diseases or the diagnosis or treatment of drug or alcohol abuse.

I am fully aware that my records contain such sensitive health information.

Specifically____

Signature____Date________________