SADDLE ROCK INSTITUTE

Authorization to Release Dental and Medical Information

Saddle Rock Institute will provide copies of dental and medical records when requested in writing and paid for by the patient. Records are released consistent with the following:

- Requests must be made in writing and be signed and dated by the patient. Use of this form is not required but will facilitate processing of requests.
- Payment for requested records must accompany written requests or be received prior to processing for requests.
- Payment for all treatment rendered at Saddle Rock Institute is expected prior to the release of records.
- Requests may take 3-5 business days to be processed after receipt of completed request(s) and applicable fees.
- A form of ID will be requested at the time of pick up. If someone other than the patient will pick up the record, a written and signed statement by the patient identifying the person is necessary with a form of ID.

Patient Name:_____ Patient Date of Birth:_____

Patient Address:_____ Patient Phone #:_____

Purpose(s) or need for which information is to be used:_____

Dental/Medical Records to be released from:
Saddle Rock Institute
7380 South Gartrell Road
Aurora, CO 80016
Phone: 720.826.8900
Fax: 720.826.8899
Email: info@saddlerockinstitute.com

Dental/Medical Records to be released to:
Name:_____
Address:_____
_____
_____
Email:_____

	Please circle:
Treatment Progress Notes	$0 printed / $0 digital
X-ray Imaging	$0 printed / $0 digital
Cone Beam CT (CBCT)	$10 per request / digital not available
Other Forms	$0 printed / $0 digital
Mailing/Processing Fee (unless picked up or emailed)	$5.00 per request

AUTHORIZATION: I request and authorize Saddle Rock Institute to release the information specified above to the organization, agency or individual names on this request. I understand that unless I direct otherwise in writing, the information to be released may include information regarding the following condition(s) if any; psychological or psychiatric condition; sickle cell anemia, drug abuse, alcoholism or alcohol abuse. I certify that this request has been made voluntarily and the information given above is accurate the best of my knowledge. I understand that I may revoke this authorization at any time, except the extent that action has already been taken to comply with it. Re-disclosure of my dental and medical records by those receiving the above authorized information may not be accomplished without my further written consent. This consent will automatically expire upon satisfaction of this request by Saddle Rock Institute.

Signature of the Patient/Authorized Representative:_____

Printed Name:_____

Relationship to Patient (if applicable):_____

Date:_____