

Stefanie Shore, DDS
5723 Marconi Avenue
Carmichael, CA 95608
(916) 966-4341



Authorization for the Release of Dental Records

I hereby authorize _____ to release the information (including x-rays with any and all chart notes and specialist correspondence) in the dental record of _____ to: trina.shoredds@gmail.com

This authorization is effective now and will remain in effect until 12/31/2026. I understand that I may receive a copy of this authorization.

X _____ (patient signature)

X _____ (parent or guardian signature)

If not signed by the patient please indicate relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

NOTE: This authorization is intended to comply with applicable state laws. It is not intended as a “Consent” or “Authorization” for the use and disclosure of Protected Health Information (PHI) under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or its implementing regulations. The medical provider to whom this authorization I directed should ensure that he or she is in compliance with applicable HIPAA requirements before releasing the requested records.

CAUTION: If you intend to use the requested information for any purpose other than providing medical treatment, 45 CFR Section 164.502 requires that you make reasonable efforts to limit your request for PHI to minimum necessary to accomplish the intended purpose of the request.