



**Agnieszka B Kumar, DDS**  
8600 US Highway 14, Suite 203  
Crystal Lake, IL 60012  
Phone: 815.356.0033 Fax 8153.356.0035  
www.oaksdental.com

## Authorization for Release of **Protected Health Information – Dental Record**

### 1. Patient Information:

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Address & Phone \_\_\_\_\_

### 2. Recipient Authorization:

I (patient name or representative) \_\_\_\_\_,  
do hereby authorize

Name of the doctor or practice \_\_\_\_\_

Address & Phone \_\_\_\_\_

to release a copy of my dental record to

**The Oaks Dental Center, Ltd.**  
**8600 US Hwy 14, Suite 203**  
**Crystal Lake, IL 60012**  
**Phone: 815.356.0033**  
**Email: [oaks@oaksdental.com](mailto:oaks@oaksdental.com)**  
**Fax: 815.356.0035**

### 3. Information to be released:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Entire dental record | <input type="checkbox"/> Full-mouth series | <input type="checkbox"/> Panoramic x-ray |
| <input type="checkbox"/> Bite wings           | <input type="checkbox"/> Individual x-ray  |  |

\_\_\_\_\_ (signature) \_\_\_\_\_ (date)

\_\_\_\_\_ (print your name)

If signed by anyone other than the patient, state the relationship to patient and/or legal authority for signing:

\_\_\_\_\_