Release of Records

I, ______________________________, (Patient) hereby allow Dr Ali Arastu, and/or staff at (Round Rock Periodontics) to release my dental records.

In the event that my insurance company requests all, or a portion of my records, I give my consent to Round Rock Periodontics to release such information. I give Round Rock Periodontics full permission to discuss my medical history, diagnosis and treatment plan with my physicians and dentists, as applicable. I give Round Rock Periodontics full permission to release information to laboratories, insurance companies and/or other outside sources relating to my treatment. I understand all outside sources are HIPPA compliant.

I understand that records may include but are not limited to: dental x-rays, dental photographs, periodontal charting and treatment notes.

______________________________ ______________________________
Signature of Patient Date

______________________________ ______________________________
Signature of Witness Date