



**RELEASE OF INFORMATION AUTHORIZATION**

I hereby authorize all dentist offices, hospitals, institutions, physicians, clinics, employers (past and present), laboratories, insurance companies, and/or all government agencies to release to the Kansas Dental Board or its representatives any and all information, records, files or documents in any form pertaining to \_\_\_\_\_ in their possession or control. (patient name)

The Board in place of the original may use a photo static copy of this release. This release shall expire one year from the date below.

\_\_\_\_\_  
Type or Print Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Parent/Guardian Signature (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\*\*\*\*\*  
**BOARD USE ONLY- DO NOT WRITE BELOW THIS LINE**  
\*\*\*\*\*

TO \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

Please submit copies of all records indicated below regarding the above release of information authorization. Thank you.

- |  |                          |
|--|--------------------------|
| _____ Fact sheet   | _____ All dental records |
| _____ Consultation   | _____ History            |
| _____ X-ray reports  | _____ Progress notes     |
| _____ Laboratory reports   | _____ Dentist orders     |
| _____ Notes of dentists, dental hygienists, professional and practical nurses and nurse anesthetists |                          |

Other \_\_\_\_\_

Send information to: **Kansas Dental Board**

# Kansas Dental Board

PLEASE TYPE OR PRINT CLEARLY

NATURE OF YOUR COMPLAINT (INCLUDE DATES OF TREATMENT  
AND NAMES OF OTHER DENTISTS WHO TREATED YOU.)

\*\*\*USE ADDITIONAL PAGES AS NECESSARY\*\*\*  
ENCLOSE COPIES OF ANY BILLING STATEMENTS, LETTERS OR RECORDS