

## Authorization for the Release of Dental Records

I hereby authorize \_\_\_\_\_, DDS to release the information in the dental record of \_\_\_\_\_ (patient's name) to

Norman S.M. Cheung, DDS  
1441 Kapiolani Blvd, Suite 1207  
Honolulu, Hawaii 96814

Any and all information may be released including, but not limited to, mental health records, drug and/or alcohol abuse records, and/or HIV test results, if any, except as specifically provided below:

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*This authorization is effective now and will remain in effect for 30 days after the date indicated below. I understand that I may receive a copy of this authorization. I further understand that some offices may charge a fee to cover the cost of the transfer.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
If not signed by patient, please indicate relationship to patient

COPY TO BE PLACED IN PATIENT'S CHART