





77 South High Street, 17th Floor  
Columbus, Ohio 43215-6135



614/466-2580 • Fax: 614/752-8995  
www.dental.ohio.gov

## OHIO STATE DENTAL BOARD RELEASE OF INFORMATION

I, \_\_\_\_\_ do hereby authorize the release of  
Parent/Guardian/Patient  
information and/or original records concerning \_\_\_\_\_, specifically  
Patient's Name  
which relate to medical/dental treatment rendered by any health care provider or facility, either at an office facility or any other hospital and/or healthcare treatment center or facility. I hereby authorize the release of information, the original record, or a color copy of the original records regarding any treatment rendered at any of the aforementioned locations by any practitioner, including, but not limited to: **radiographs (originals or scanned to a CD), insurance claim forms, financial records (computer generated or otherwise), progress notes, treatment plan, photos, models, work authorization forms, prescriptions, correspondence and any other documents related to or involving your care and treatment of the named patient.**

I authorize the release of information and/or records to the **Ohio State Dental Board** or its authorized representative. I release any person, institution, organization, company or hospital from any liability as a result of providing the above-stated information and/or records to the **Ohio State Dental Board**. I further authorize the use of a copy of this release for use in obtaining the above-stated information and/or records.

SIGNED: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

PATIENT DATE OF BIRTH: \_\_\_\_\_ DATE: \_\_\_\_\_

RETURN THIS FORM TO:

**OHIO STATE DENTAL BOARD**  
77 South High Street, 17th Floor  
Columbus, Ohio 43215-6135