Touro College of Dental Medicine
AT NEW YORK MEDICAL COLLEGE
Where Knowledge and Values Meet

Release of Information Form

To request the release of patient information, please scan and email this completed form to dentalhealth@touro.edu or fax it to 914.594.2681. Please allow up to 10 business days for a response.

I,_____, the undersigned, hereby authorize the following individual, agency, institution or organization of Touro College to release and provide to:

Name: _____

Address: _____

Email:_____with copies of documents as listed below.

□ I acknowledge that I understand the purpose of the request and that authorization is hereby granted voluntarily.

Reason: □ Leaving the practice □ Personal Records □ Other: _____

Patient Information:

Patient Name: (First)_____(Last)_____(Middle)s_____

Address: _____

Phone Number:_____ Date of Birth (mm/dd/yy):_____/_____/ _____

Requested Information or Documents:

□ Radiographic Images □Photographs □ Other (Specify) _____

NOTE: I understand that this release is valid for a period of one hundred and twenty (120) days.
I further understand that I may cancel or revoke this authorization at any time in writing.

Dated On:_____/_____/ _____

By my signature below, I consent to the release of the above listed information/documents.

Printed Name of Patient: _____

Printed Name of Parent or Legal Guardian: _____

Signature of Patient, Parent, Legal Guardian: _____

OFFICE USE ONLY

Release date:_____/_____/_____ Scanned to Axium by: _____

Comment: _____