RICHARD L. DAFFURN, D.D.S.
SONOMA MEDICAL PLAZA
181 ANDRIEUX ST., STE 104
SONOMA, CA 95476
PHONE (707)996-4585
FAX (707)996-4059

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**AUTHORIZATION FOR THE RELEASE OF DENTAL RECORDS**

I hereby authorize_____
(name of dentist, physician, clinic) (phone & fax number)

to release the dental records of _____

_____ _____
Signature Date

_____
Print Name

Please send my recent x rays and records to:

**RICHARD L. DAFFURN, DDS**
**181 ANDRIEUX STREET, SUITE 104**
**SONOMA, CA 95476**

Digital x rays may be emailed to the office:

**Gina.Dr.Daffurn@comcast.net**

This request must come from the patient whose name is on the records. If not signed by the patient, please circle the relationship below:

Parent or Guardian of minor patient

Guardian or Conservator of an incompetent patient

Beneficiary or Personal Representative of deceased patient

This authorization is intended to comply with all applicable state laws. It is not intended as a "Consent" or "Authorization" for the disclosure and use of any Protected Health Information (PHI) which is protected under the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). The provider to whom this authorization is directed should ensure that he or she is in compliance with all applicable HIPAA requirements before releasing any requested records.

NOTES: