California authorization for the release of dental records

I hereby authorize A. Marcela Torres, DDS to release the information in the Dental record of

_____ to _____
(Patient's name) (Name of dentist, physician, clinic, or patient's representative)

_____
(Address)

Any and all information may be released including, but not limited to, mental health records protected by the **Lanterman-Petris-Short** Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below.

This authorization is effective now and will remain in effect until _____ (date)
I understand I may receive a copy of this authorization

Signed: _____ Date: _____

If not signed by the patient please indicate relationship:
☐ Parent or guardian of minor patient.
☐ Guardian or conservator of an incompetent patient.
☐ Beneficiary or personal representative of deceased patient.