Bernal DENTAL CARE
Yuhao Gao, DDS, Ph.D

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California Authorization for the Release of Dental Records

I hereby authorize **Bernal Dental Care, Yuhao Gao** , D.D.S. to release the information in the dental record of _____ (Patientôs name) to

_____

(Name of Dentist, Physician, Clinic, or Patientôs 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.

_____

I understand that I may receive a copy of this authorization.
Signature: _____ 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

Enclosed:

_____ Last full-mouth series

_____ Last bitewing series

_____ Last panoramic film

_____ Last periodontal probing record

_____ Others _____