Verification of Identity

This form illustrates how a dental practice might document the verification of the identity and authority of a person requesting patient information.

Please provide us with the following information.

Name of patient whose information you are requesting: _______________________

Patient's date of birth: ______________________

The specific patient information that you are requesting:

____

Your name:____

Address:____

City:____________________________ State:__________ Zip:_______________

Describe your authority to access this information:

____

If you are a patient's personal representative:

Relationship to Patient____

I certify that the above information is correct.

Signature: _____________________________________ Date:____________________

Dental Staff: Describe documentation presented by the requester:

____

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