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COMPREHENSIVE & ESTHETIC DENTISTRY

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Authorization to Release Health Information

Expires upon one time release

***Name of Patient:*____*Date of Birth:*___________**
***Address*____**
***City, State, Zip*____**

I authorize* _______________________________ *to release the following health information:
____
____
____

***Please forward/release my health information to:* ____________________________________**
____
____

This authorization shall be in effect until the information has been forwarded as requested.

Patient Information
I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization by sending a written notification to the address above and that a revocation is not effective if the information has already been disclosed, but will be effective going forward.

*I understand that I have the right to inspect or copy, for a fee, the protected health information as described in this document. I can do this by written notification to:*_________________________

____ *Date:*_______________
Signature of Patient or Personal Representative (Description of Authority)
Attach necessary documentation of Personal Representative's Authority

Revised March 2010