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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