Complete Dentistry for All Ages

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Authorization to Release Health Care Information

Patient Name :_____ Date of Birth:_____

SSN:_____ Patients Previous Name (if any):_____

Dentist Name:_____

Practice Name:_____

I request and authorize the above doctor listed and practice to release health care information of the patient named above to:

Dentist Name:_____

Address:_____

City, State, Zip:_____

Email Address:_____

This request and authorization applies to health care information relating to the following treatment, condition or dates of treatment: _____

or All health care information: _____

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor of the practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement, I can:

- **Sign and date a form available from the doctor or practice called, "Revocation of Authorization for Use and Disclosure of Health Care Information" or**
- **Write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. My letter must also include the name(s) or other specific identification of the person(s) that I no longer want to receive the information might disclose it. Federal or state privacy laws may no longer protect the information.**

_____

Signature of patient or patient's authorized representative

_____ _____

Relationship to patient **Date**