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AUTHORIZATION FOR RELAEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name:

Patient Address:

Patient Phone Number:

I authorize the professional office of my dentist named above to release health information identifying me {including if applicable, information about HIV infection, information about substance abuse treatment, and information about mental health services} under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released {name(s) or class(es) of recipients}:

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual}:

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked. Sent this note to the office at the address above.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

{For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.}

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated_____ Patient signature_____

If you are signing as personal representative of the patient, describe your relationship and the source or your authority to sign this form:

Relationship to Patient_____ Print Name_____