Authorization For Release of Dental/Health Care Information

1. I, __________________, hereby give my consent to Dr.______________ to release to:

Name____

Address____

2. Information from and copies of the dental/health care records of:

Patient Name____

Address____

Birth Date and/or Social Security No.____

Phone____

Date(s) of
Treatment____

3. Patient authorizes Doctor _____________________to release his/her entire dental/health care records, including information related to HIV infection or AIDS, any communicable disease or infectious disease, records and any other dental or health care records in any format.

4. Purpose(s) of Release:

________Dental/Health Care ________Personal Information

________Insurance ________Other_____________________________

5. This authorization shall be effective following the date of signature. However I understand that this authorization may be revoked at any time by giving written notice to the above-named dentist. A photocopy of this authorization shall constitute a valid authorization.

6. If deemed necessary by Dr._____________, I authorize this information to be sent via facsimile (fax) transmission.

7. The dentist and his/her employees are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Patient or Representative_____________________ Date__________________________

Relationship to Patient (if applicable)____

NOTICE TO RECIPIENT

The recipient of the enclosed information is not authorized to use this patient's dental/health care records for any purpose other than for that stated above or to disclose any information from the record to any other person or facility without specific written authorization from the patient to do so.