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AUTHORIZATION TO RELEASE MEDICAL/DENTAL CONFIDENTIAL INFORMATION

I, _____ Date of Birth: _____ authorize _____ to:

_____ release to:
_____ obtain from:

Name of Person / Practice: _____ Phone: _____

Address _____City _____ State ____ Zip_____

Email address _____

The following information pertaining to myself:

_____ Report
_____ Diagnosis
_____ Test results
_____ X-rays
_____ Other (specify) _____

For the purpose of:
_____ Evaluation/assessment and/or coordinating treatment efforts
_____ Other (specify) _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Privacy Officer. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or _____condition. Expiration Date: _____. If I fail to specify an authorization date, event or condition, this authorization will expire in 180 days.

I understand that authorizing the disclosure of this dental/ health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or request a copy of the information used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re disclosure and the information may not be protected by federal confidentiality rules.

_____ _____

Signature of Patient or legal Representative Date