AUTHORIZATION TO RELEASE DENTAL INFORMATION

CHECK EACH PERSON THAT YOU APPROVE TO RECEIVE INFORMATION

- ☐ Self
- ☐ Spouse
- ☐ Domestic Partner
- ☐ Parent/ Guardian _____

DESCRIPTION OF INFORMATION TO BE RELEASED

- ☐ Results of lab tests
- ☐ X-rays
- ☐ Medical History
- ☐ Other _____

CHECK PREFERRED COMMUNICATION

- ☐ Phone
- ☐ Voicemail
- ☐ Email

PATIENT AUTHORIZATION

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization maybe subject to disclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
THIS AUTHORIZATION SHALL BE IN EFFECT UNTILL REVOKED BY PATIENT.

Printed Name	Signature	Date