AUTHORIZATION TO RELEASE HEALTH INFORMATION

Expires upon one-time release

Patient Information:
Name of Patient:_____ Date of Birth:_____
Address:_____
City, State, Zip:_____

I authorize the practice below to release my health information:

_____
_____
_____
_____

Please forward/release my health information to:

_____
_____
_____

The information below provided at the request of the patient. (Describe PHI needed)

_____
_____

This authorization shall be in effect until the information has been forwarded as requested.

Patient Information

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to_____.

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority (attach necessary documentation)

Arden Dental Group