Anderson Dental

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____ Birth date: _____

Patient Address: _____

Patient Phone Number: _____

I authorize the release of health information identifying me including any information about my dental treatment and/or dental treatment plans, under the following terms and conditions:

1. **Information to be released:** Current X-Rays including full mouth (FMX), panoramic, and bitewings. Date of last Adult prophy or Perio maintenance and exam, and Scaling and Root Planing date if completed.

2. **Previous Provider:** Name and phone number of previous provider the information is to be released from.

3. **To Whom:** The information be released (recipients).

4. **The purpose for the release and Expiration:** If the authorization is initiated by the individual, it is permissible to state "at my request" as the purpose, if desired by the individual. Expiration or event relating to the individual or purpose of 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 or electronic note telling us that your authorization is revoked. Send this notice to Loren Anderson at Anderson Dental.

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.

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.

Patient signature: _____ Date: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient.

Relationship to patient: _____ Print Name: _____