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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. To whom may the information be released:
    a. Referring specialists (endodontist, periodontist, orthodontist, oral surgeon, prosthodontist)
    b. Your dental insurance provider
2. Detailed description of the information to be released:
    a. All of medical records including name, date of birth, address, phone number
    b. Only the following information/other:
    _____
3. The reason why I am giving permission to send
    a. Insurance reimbursement for services
    b. To assist referring specialists in coordination of your care
    c. Patient's request

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. You are allowed to get a copy of this form. You are allowed to look at your records or get a copy of your records before they are sent.

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 note to the office contact person listed at the top of this form.

If you choose not to sign this form we will not be able to:

1. Submit insurance claims on your behalf for reimbursement. *In this case you must pay for all services out of pocket.*
2. Facilitate your care with referring specialists (scheduling appointments or sharing diagnostic information).

When your health information is disclosed as provided in this authorization, the recipient may not have a legal duty to protect its confidentiality (see bullet list below). 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's Signature: _____