AUTHORIZATION TO RELEASE DENTAL INFORMATION

Patient's Name: ________________________________ Date of Birth: __________________

SSN: ____________________________ Treating Endodontist: ________________________

I request and authorize the above listed endodontist and practice to release health care information of the patient named above to:

Name: ____

Address: ____

City: ____________________________________ State: _____________ Zip: ___________

INFORMATION REQUESTED:

Date(s)Treatment: ____

Or _____ All health care information

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, or on ____-____-20___ or must be revoked in writing by the patient. If it is revoked in writing the document must contain the statement that the patient wants to cancel their authorization to disclose health care information. It must also contain the name or other specific identification to the person (s) that the patient no longer wants to receive information and must be signed and dated.

Once my endodontist gives out the information that I want released, I know that my endodontist has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws no longer protect the information.

A copy of this authorization or my signature thereon: _____may, or _____may not be used with the same effectiveness as an original.

________________________________ ________________________________

PATIENT NAME (print) PATIENT SIGNATURE

________________________________ ________________________________

PERSON AUTHORIZED TO SIGN FOR PATIENT (print) DATE

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STATE HOW AUTHORIZED