Authorization to Release Health Care Information

Patient's name: _____ Date of Birth: _____
SSN: _____ Previous name: _____
Doctor's Name: Dr. Ronald Roessler Practice Name: Five Points Dental

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

Name: _____
Address: _____
City, State: _____ Zip Code: _____
or E-mail: _____

This request and authorization applies to health care information relating to the following treatment, condition, or dates of treatment: _____
_____

Or ___ All health care information

Or ___ Other: _____
_____

THIS AUTHORIZATION EXPIRES ON _____ or _____ DAYS AFTER THE DATE IT IS SIGNED; or WHEN THE FOLLOWING EVENT OCCURS
_____
_____

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

I understand that in order to cancel this agreement I must write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter.

Once my doctor gives out the information that I want released, I know that my doctor 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 may no longer protect the information.

_____
Signature of patient or patient's authorized representative Date signed