



AUTHORIZATION TO DISCLOSE DENTAL INFORMATION

PATIENT INFORMATION

Patient Name _____

Former Name (If Any) _____

Daytime Telephone _____

INFORMATION TO BE RELEASED FROM

I hereby authorize (name of organization) _____

To release the following dental information contained in patient's dental record.

INFORMATION TO BE RELEASED TO

Name of Dentist/Surgeon _____

Street Address _____

City/State/Zip _____

Phone# _____

PURPOSE FOR THE REQUEST

(Please check a box)

- Moving
- Treatment or Consultation
- Dissatisfaction
- Change of Insurance Plans
- At patients request
- Other (specify) _____

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE AFTER ONE YEAR FROM THE DATE OF SIGNING

The undersigned may revoke this authorization at any time by providing written notice of revocation.

The recipient of this information understands that it is prohibited from making any disclosure of this information unless further disclosure is expressly permitted by written consent of the undersigned or otherwise permitted by applicable law.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that Dr. Graig Brown DDS, MS may not condition my treatment on whether I sign this authorization form unless specified above under Purpose for Request. I can inspect or receive a copy of the protected health information to be used or disclosed. I authorize Dr. Graig Brown DDS, MS to use the protected health information specified above.

Signature of Patient OR Legal Representative **Date** **Please Print Name of Signing Party**

Please print and Fax this Authorization to (520) 790-2152