Authorization for Release of Health Information

Patient Name: _____ Date of Birth: _____

I hereby authorize Eagle Dental to release my dental/health information to the following individual or organization:

_____

Address/Email/Fax of Recipient: _____

Purpose of Release (e.g., personal use, insurance, referral): _____

Information to be released (check all that apply):
[ ] Entire dental record
[ ] X-rays
[ ] Treatment notes
[ ] Billing records
[ ] Other (specify): _____

This authorization will be effective for the duration of the patient's care with Eagle Dental.

I understand that I may revoke this authorization at any time by providing written notice to Eagle Dental, except to the extent that action has already been taken in reliance on this authorization.

Signature of Patient or Legal Representative: _____

Date: _____

Relationship to Patient (if applicable): _____

NOTICE: Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA privacy regulations.