Forrest and Forrest Family Dentistry

Authorization for Release of Information

Name of Patient_____Date of Birth_____

FORREST AND FORREST FAMILY DENTISTRY is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information:
List each person/entity that you approve to receive information

_____Relationship_____

_____Home Number _____Cell

_____Relationship_____

_____Home Number _____Cell

_____Relationship_____

_____Home Number _____Cell

Information To Receive: Voice Mails, Appointment Reminders, Financial Arrangements, Treatment Recommendations, Treatment Results, Results From X-rays, Lab Tests Results, and Insurance.

Patient Information
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing. This authorization shall be in effect until revoked by the patient.

_____Date _____
Signature of Patient, Guardian, or Representative
Description of Personal Representative's Authority (attach necessary documentation)

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