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Office Contact: Eleisha J. Nickoles, DDS

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name:

I authorize the professional office of my dentist named above to release health information identifying me under the following terms and conditions:

1. Detailed description of the information to be released: treatment, payment and health care operations.

2. To whom may the information be released: referrals, health or dental care plans, collection agencies or attorneys.

3. The purpose(s) for the release: to have no barriers in providing the best possible dental care for our patients.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated:
Signature:

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____Print Name_____

Source of Authority_____