Medical Release Authorization

Patient Name_____ Date _____

Patient Date of Birth_____ Patient SSN#_____-_____-_____

I authorize Dr. Stacy Manlove D.D.S., to communicate with outside physicians and their staffs, other dentists and their staffs, pharmacists and their staffs, insurance company's, and any other health care professional, concerning my medical/dental health and my billing/account records held by:

Stacy Manlove D.D.S.
3205 S. Alameda
Corpus Christi, Texas 78404
Phone: (361) 888-8603
Fax: (361) 888-8610

I further authorize the electronic, digital, or verbal communications of records or information between Dr. Stacy Manlove D.D.S., and any insurance company, physician's office, dental office, or any other healthcare agency associated with the patient's dental treatment. All treatments, accidents, and illness are covered by this release. I further agree to hold harmless the staff and officers of Dr. Stacy Manlove D.D.S., concerning the release of any dental/medical record(s) authorized by this document.

_____ _____
Patient Signature Date

_____ _____
Witness Date

I **do/do not** authorize the release/discussion of sensitive medical records or those records whose disclosure is protected by law. These include records concerning communicable diseases, mental health records, or records concerning chemical dependency. I understand that refusal to release this information may effect the standard of care available to the patient as the staff would be limited in disclosure of my complete medical condition.

_____ _____
Patient Signature Date