

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Phone: _____ Social Security: _____

Patient Address: _____

I authorize the professional office of my dentist named below to release dental/health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services].

Dentist or Dental Practice Name: _____

Dentist Phone: _____ Dentist Fax: _____

Dentist Address: _____

Information authorized to be released: (Please Check) X-Rays Chart Notes Account Notes

Release Information to: Heath Lefberg, DDS, PA

Address: Two Town Square, Suite 210, Asheville, N.C. 28803

The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual): _____

Expiration date or event relating to the individual or purpose for the release: _____

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. 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 DENTAL/HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature (or Parent/Guardian if Minor): _____ Date: _____