

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize Mark N. Dye, DMD, LLC to release/receive the following information from the records of:

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

To be released to:

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Information to be released: (Circle all that apply)

Entire Record      Lab Results      Assistant Notes      Medication Record

X-Rays

Other: \_\_\_\_\_

For dates of service rendered \_\_\_\_\_ through \_\_\_\_\_

Records are to be released for the purpose of: \_\_\_\_\_

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I understand that I can revoke this authorization by providing written notice to the office manager of Mark N. Dye, DMD, LLC at the address listed above. I also understand that if the information has been released upon this Authorization, that revocation will not be valid.

**I PLACE NO LIMITATIONS ON THE RELEASE OF HISTORY OF ILLNESS OR DIAGNOSTIC OR TREATMENT INFORMATION, INCLUDING BUT NOT LIMITED TO ANY INFORMATION CONTAINED IN MY RECORD CONCERNING TREATMENT FOR ALCOHOL, DRUG ABUSE OR DEPENDENCY, MENTAL ILLNESS, PSYCHIATRIC OR PSYCHOLOGICAL ILLNESS OR AIDS.**

I understand that I am waiving my rights to privacy by releasing my information to the parties listed above and this information may be redisclosed to the receiving party.

I understand that this Release will expire within ninety (90) days from the date listed below.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient's Guardian or Capacity \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

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For Office Use Only:

Request completed by: \_\_\_\_\_

Method of Release: Mail Pick-Up Fax