Alfred J. Lanfranchi, DDS

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Alfred J. Lanfranchi, DDS 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: (Check all that apply)

Entire Records Lab Results Assistant Notes Demographics

X-Rays Orders Dictated Reports Medication Record

Other:_____

For dates of service rendered_____through_____

Records are to be released for the purpose of:_____

I understand that I can revoke this authorization by providing written notice to the office manager of Alfred J. Lanfranchi, DDS 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 re-disclosed 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_____

For Office Use Only:
Request completed by: _____
Method of Release: Mail Pick-Up Fax