dental health PROFESSIONALS

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Authorization for Release of Dental/Health Care Information

I, _____ hereby give my consent to Dental Health Professionals, PO Box 889, Cadillac, MI 49601, to release to:

Name: _____
Address: _____
_____
Phone: _____

information from and copies of the dental/health care records of:

Patient Name(s): _____
Birth Date(s): _____

I authorize Dental Health Professionals to release the above-named patient(s)'s entire dental/health care records, including information related to HIV infection or AIDS, any communicable disease or infectious disease, records and any other dental or health care records in any format. This authorization shall be effective following the date of signature. However, I understand that this authorization may be revoked at any time by giving written notice to Dental Health Professionals. A photocopy or fax of this authorization shall constitute a valid authorization.

Dental Health Professionals is released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

_____ _____
Patient or Representative *Date*

_____
Relationship to Patient (if applicable)