dental health
PROFESSIONALS

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Authorization for Release of Dental/Health Care Information

I, _____ hereby give my consent to _____to release to:

Dental Health Professionals
7800 US 131 S. Cadillac, Mi 49601
Phone: 231-775-9797
Email: info@dhpcadillac.com

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

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

I authorize _____ 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.

_____ _____
Patient or Representative *Date*

_____
Relationship to Patient (if applicable)