

Drs. Hyde, Bailey, Miller and Cremer
AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____ to disclose my child's identifiable health information as described below, which may include information concerning medical history, performed dental treatment and proposed dental treatment or any other such related information. I understand that this authorization is voluntary and I may refuse to sign. I further understand that my child's healthcare and payment of my child's healthcare will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

Patients Name (print) Date of Birth Social Security #

Description of information to be released: (check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Medical History | <input type="checkbox"/> Proposed Treatment | <input type="checkbox"/> Billing Records |
| <input type="checkbox"/> Radiographs | <input type="checkbox"/> Hygiene Records | <input type="checkbox"/> Insurance Information |
| <input type="checkbox"/> Operative Records | <input type="checkbox"/> Orthodontic Records | <input type="checkbox"/> Other |

Description of the purpose of the use and/or disclosure: _____

The health information described herein shall be released to:

Name Address City ST Zip

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be effective until _____.

I further understand that I may revoke this authorization at any time by notifying the office of Drs. Hyde, Bailey and Miller in writing. I also understand the revocation must be signed and dated with a date later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Patient (18yrs or older) or Parent/Guardian

Date

Print Name

Relationship to Patient