

Drs. Hyde, Bailey, Miller and Associates  
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