AUTHORIZATION TO RELEASE HEALTH INFORMATION

HAYES BARTON DENTISTRY

This form permits the office of Hayes Barton Dentistry to request, use and/or release the patient's health information for the purpose(s) described below.

Patient Name (Print):_____

Date of Birth (MM/DD/YYYY):_____

Main Contact Number:_____ Select One: ☐ Home ☐ Cell ☐ Work

Mailing Address:_____

_____

Recipient(s): This practice may request, use and/or release the information checked below to the following person or entity for the purpose(s) listed on this form.

Name:_____

Email:_____

Fax:_____ Office Number:_____

Check the type(s) of information to be requested, used and/or released:

☐ Clinical Images – includes any and all x-rays, photos or images (pre or post)

☐ Records specific to a certain condition

☐ Lab/diagnostic results of any date needed

☐ Billing/insurance records

☐ Office visit notes

Communicating with your family, friends, or caregivers: This practice may communicate to the family members, friends or caregivers listed below (write names):

_____

_____

_____

☐ All Information ☐ Prescriptions ☐ Appointments (in all manners)

☐ Billing/Insurance ☐ Medical Records ☐ Treatment Planning

Patient/Parent/Personal Representative Signature:_____

Date:_____

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