Authorization for Release of Identifying Health Information

Patient Name:____________________________________

Patient Number:__________________________________

Address:____

Phone number____________________________________

I authorize the professional office of my dentists to release health information identifying me (including if applicable, information about HIV infection or AIDs, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released (name(s) or class(es) of recipients):

3. The purpose(s) for release (If authorization is initiated by the individual, it is permissible to stat "at the request of the individual" as the purpose, if desired by the individual

4. Expiration Date or event relating to the individual or purpose for the release:

Acknowledgement of Receipt

I acknowledge that I received a copy of Daniel Bergman D.D.S., notice of Privacy Practices

Patient Name:____________________________________

Signature:____ Date:____________

I HAVE READ AND UNDERSTAND THIS FORM: I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated:________________ Patient/Guardian signature______________________