**AUTHORIZATION FOR RELEASE OF INFORMATION**

Name of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street address City State Zip

Fuller Dental is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient’s instructions.

**Check entity/person that you approve to** **Check description of information to be**

**Receive information. released to entity/person at left.**

□ Voice Mail (Home or Mobile) □ Appointment Reminders

□ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Appointment Reminders, X-Rays, Financial

 (Provide Email Address)

□ Spouse\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Appointment Reminders

 (Provide Name and Phone Number) □ Financial

 □ Treatment Plans

□ Parent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Appointment Reminders

 (Provide Name and Phone Number) □ Financial

 □ Treatment Plans

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Appointment Reminders

 (Grand-parent, Step-parent, Nanny) □ Financial

 (Provide Name and Phone Number) □ Treatment Plans

**Patient Information**

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

*I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.*  This authorization shall be in effect until revoked by the patient.

Signature of Patient or Personal Representative Date

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