Authorization to Release Medical/Dental Information

I grant my permission to you or your assignee, to discuss my protected health/dental information with:

____ ______________________________

(name) (relationship)

____ ______________________________

(name) (relationship)

____ ______________________________

(name) (relationship)

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected information:

__________ Treatment Plans

__________ Medical Information

__________ Financial Information

Unless specified this authorization will remain in effect, until I revoke it in writing.

Signature: ___________________________ Date: _________________ Relationship to patient: _______________

(signature of patient, parent or guardian)