FAIRVIEW DENTAL MEDICAL INFORMATION RELEASE AND AUTHORIZATION FORM

Patient_______________________________________ **Date of Birth** _____/_____/_____

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of information including the entire contents of dental record, including diagnosis, treatment details and financial information.

This information may be released to:
( ) Spouse ____

( ) Child(ren) ____

( ) Other ____

( ) Information is not to be released to anyone

I understand that I have the right to revoke this Authorization, in writing, at any time by notifying this office. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule. I understand that my dental provider cannot condition treatment on whether I sign this Authorization.

This Authorization will remain in effect until terminated by me in writing or until the following date:
____________________________________.

MESSAGES

Please call ( )my home ( ) my work ( ) my cell :___________________________________

If unable to reach me:
( ) you may leave a detailed message
( ) please leave a message asking me to return your call
( ) other ____

It is my responsibility to notify Fairview Dental of changes and to complete a new form.

Patient/Authorized Person Signature __________________________________ Date _____________

Patient/Authorized Person (Please Print) ______________________________

Relationship to Patient __________________________________

AUTHORIZATION FOR TREATMENT OF A MINOR BY DELEGATED PERSONS

I herby authorize that the following persons have my permission to seek and authorize dental treatment of the above named minor child in my absence and that his/her protected dental information may be shared.

Name: ____Relationship to Patient______________________ Phone Number _________________________

Name: ____Relationship to Patient______________________ Phone Number __________________________

It is my responsibility to notify Fairview Dental of changes and to complete a new form.

Patient/Authorized Person Signature __________________________________ Date _____________

Patient/Authorized Person (Please Print) ______________________________

Relationship to Patient __________________________________