

# CHESTNUT FAMILY & COSMETIC DENTISTRY

## Authorization to Release Health Information

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**Patient Information:**

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone \_\_\_\_\_

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**At my request the following information may be released:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Entire record | <input type="checkbox"/> Financial records                    | <input type="checkbox"/> Office visit notes |
| <input type="checkbox"/> X-Rays        | <input type="checkbox"/> On site record review by the patient |   |

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**Entity or person who will receive the information:**

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone \_\_\_\_\_

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**This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.**

**Patient Rights:**

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that released information may include a communicable disease diagnosis such as HIV.

\_\_\_\_\_ Date \_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority (attach necessary documentation)