AUTHORIZATION FOR RELEASE OF MEDICAL/DENTAL RECORD INFORMATION

PATIENT NAME:_____ BIRTHDATE:_____
LAST FIRST MI

STREET ADDRESS:_____ APT#_____

CITY:_____ STATE:_____ ZIP:_____

TELEPHONE(HOME):_____ TELEPHONE(WORK):_____

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RELEASE RECORDS FROM: _____
OFFICE NAME

_____
ADDRESS CITY STATE ZIP

TELEPHONE:_____ FAX: _____

RELEASE RECORDS TO: _____
OFFICE NAME

_____
ADDRESS CITY STATE ZIP

TELEPHONE: _____ FAX: _____

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I HEREBY AUTHORIZE YOU TO USE OR DISCLOSE ANY MEDICAL/DENTAL INFORMATION AS REQUESTED. I AM AWARE THAT THE OFFICE OF DR. H. TALBOTT TEBAY D.D.S. AND ASSOCIATES CANNOT CONTROL HOW THE RECIPIENT USES OR SHARES THE INFORMATION PROVIDED, AND THAT LAWS PROTECTING ITS CONFIDENTIALITY MAY OR MAY NOT PROTECT THIS INFORMATION ONCE IT HAS BEEN DISCLOSED TO THE RECIPIENT.

INFORMATION WILL NOT BE RELEASED WITHOUT A VALID SIGNATURE BELOW. THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE SIGNATURE DATE. I CAN HOWEVER, CANCEL THIS AUTHORIZATION IN WRITING AT ANY TIME. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO MY INSURANCE COMPANY WHEN THE LAW PROVIDES MY INSURER WITH THE RIGHT TO CONTEST A CLAIM UNDER MY POLICY.

I CERTIFY THAT THIS REQUEST HAS BEEN MADE FREELY, VOLUNTARILY, AND WITHOUT COERCION AND THAT THE INFORMATION GIVEN ABOVE IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

_____ DATE:_____
SIGNATURE OF PATIENT (IF 18 YEARS OF AGE OR OLDER)

_____ DATE:_____
SIGNATURE OF PARENT OF GUARDIAN (IF MINOR PATIENT)

_____ DATE SENT:_____
SIGNATURE OF OFFICE RECORDS MANAGER

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