ADVANTAGE DENTAL

Authorization to Release Dental Information

The execution of this form authorizes the release of information covered by the Privacy Act to the party(s) listed below:

PATIENT NAME:_____

DOB: _____ SSN:_____

_____

RELEASE TO:_____Relationship:_____

Phone:_____E-Mail:_____

RELEASE TO:_____Relationship:_____

Phone:_____E-Mail:_____

RELEASE TO:_____Relationship:_____

Phone:_____E-Mail:_____

_____

AUTHORIZATION: *I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken to comply with it.*

Signature:_____

Date:_____