Patient Privacy Release Form

I consent to disclosure of the following protected health information about me to the following family members, medical or dental providers (involved in my dental care such as referring doctors), or persons (insurance companies) involved in my care or payment of my care for the following that may apply:

- All dental/medical information
- Information necessary to schedule appointments for me
- Lab results/radiographs
- Information necessary to provide for calling in or picking up prescriptions
- Information necessary to my family members, persons, and dental/medical providers
- Information necessary to bill for or submit claims for care provided for me by my dental insurance or FSA accounts

I authorize this Health Provider and/or staff to leave medical or account information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

Home/Cell Telephone _____ Yes _____ No
Work Telephone _____ Yes _____ No

Please list names of authorized persons:

_____ _____

_____ _____

Rights of the Patient

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed in this document by sending written authorization to Aubrey E. Myers, DDS. I understand that a revocation is not effective in cases where information has already been disclosed, but will be effective going forward.

I understand that I have the right to refuse to sign this authorization and that any treatment will not be conditioned on signing this authorization.

This authorization shall be effective until revoked by the patient or representative signing the authorization.

_____ _____

Signature of Patient/Parent/Guardian Date