LAKE DISTRICT FAMILY DENTISTRY

CARLTON, RICHTER & MANGUM

PATIENT RELEASE OF INFORMATION FORM

I authorize Lake District Family Dentistry to release my dental records and / or x-rays as described below:

Information Released: _____ Clinical Notes _____ X-rays

Released to:_____

Purpose of request:_____

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting the office shown above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by HIPPA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that they provide research-related treatment.)
- Compensation from a third party for the use of disclosure of my information may be received.

Patient Name (Please Print):

_____

SIGNATURE OF PATIENT OR GUARDIAN:

Signature: _____ Date: _____

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Changing Lives One Smile at a Time…