Consent to Release Information

Patient:____

Address:____

Phone: _________________ **SNN:**_______________ **DOB:**___________

TYPE OF INFORMATION TO BE RELEASED:

_____ ***ALL INFORMATION OR:*** _____ ***NONE***

____ Medical/Dental Information Only
____ Lab Results
____ X-ray Reports
____ Surgical Records
____ Accident Information
____ Financial Information Only
____ Other - please specify: ______________________________

Please check all that apply and please print names:

_____ Spouse Name: ____________________________
Phone: ____________________________
_____ Father Name: ____________________________
Phone: ____________________________
_____ Mother Name: ____________________________
Phone: ____________________________
_____ Step parent(s), print name(s):______________________
Phone ________________Phone _________________

_____ Legal Representative: ___________________________
Phone: ______________________________________
_____ Employer: ____________________________________
Address: ___________________Phone ___________
City/State/Zip: _________________________________
_____ Other (Attorney, Worker's Comp, Auto Carrier, etc.)
Name: ____________________________________
Relationship: _______________________________
Address: __________________________________
City/State/Zip: _______________________________
Phone: ____________________________________

PURPOSE OR NEED FOR THIS INFORMATION: *(Must check one)*

_____ **ANY** _____ **OTHER, PLEASE SPECIFY:**______________________________________

I hereby authorize Wawasee Family Dentistry to release information contained in my/patient's medical record. Authorization is valid for five (5) years only and may be revoked at any time prior to five (5) years by notifying Wawasee Family Dentistry in writing. I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

Signature:____Date:________