AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

Patient Name:____

Organization Providing the Information: Garrison Dental Care

This authorization allows Garrison Dental Care to release information to insurance companies, electronic claim vendors, pharmacists and dental specialist. This authorization also includes but is not limited to allowing our office to send postcard/email reminders for appointments and gives us the authorization to confirm appointments at home or work by leaving messages with family members/co-workers or on an answering machine if necessary.

All patient records are confidential and are the property of Garrison Dental Care and will not be used for any marketing purposes.

You must read and initial the following statements:

1. I understand this Authorization will expire if the patient leaves the practice. Initials:__________
2. I understand that I may revoke this Authorization at any time by notifying Garrison Dental Care in writing, but if I do, it will not have any effect on any actions Garrison Dental Care took before they received the revocation. Initials:__________

____
Signature of Patient or Representative

_______________________________________ ________________
Relationship to Patient Date

You may refuse to sign this Authorization. We cannot condition treatment on your signing of this Authorization.