Authorization for Release of Records

Patient Information			
Patient Last Name	**Patient First Name**		**MI**
Street Address			**Apt#**
City	**State**	**Zip**	
Home Phone	**Mobile Phone**		
Date of Birth			

Authorization
☐ **ImmediaDent has my permission to release information contained in the Dental Record of the above named patient.**
• I understand that I may revoke this authorization at any time by notifying ImmediaDent's Privacy Officer in writing. If I revoke this authorization, ImmediaDent will no longer use or disclose my health information as described in this authorization. However, I understand that if ImmediaDent has already relied on this authorization to make a use or disclosure, that use or disclosure will not be affected by a revocation.
• I understand that ImmediaDent will not condition my treatment on whether I sign this authorization, except in the following situation: If the information to be disclosed is the result of treatment provided to me solely for the purpose of creating information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party.
• I understand that once ImmediaDent discloses my information based on this authorization, the information may no longer be protected by federal or state privacy rules, and the recipient of the information may re-disclose it.
Information Requested (please be specific and enter date of service, if known):
Restriction and/or Exclusions (if any):

Information Released		
ImmediaDent will provide the information above to the following party:		
Name	**Telephone**	
Street Address		**Suite/Room**
City	**State**	**Zip**
Signature of Patient (if 18 years of age or older)		**Date**
Signature of Parent or Guardian (if minor patient)	**Relationship to Patient**	**Date**

ImmediaDent
Urgent Dental Care