

WINN FAMILY DENTISTRY, LLC

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Per the office of Daniel J. Winn, D.D.S.

Patient Name:

Patient Number:

Patient Address:

Patient Cell Phone:

I authorize Winn Family Dentistry, LLC to release my health information, including but not limited to: information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services under the following terms and conditions:

- 1. Detailed description of the information to be released:** X-rays and chart notes relating to patient treatment.
- 2. To whom may the information be released:** To any person, business or entity upon receipt of a legal request form signed by above patient or their legal representative or upon referral to a specialist by the treating Dentist.
- 3. The purpose(s) for the release at the request of the individual:** Continuity of care, further dental care or for legal proceedings.
- 4.** This release will stand indefinitely or until relationship is terminated by above patient or dental office.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. You have the right to revoke your authorization at any time. The only exception to your right to revoke is if we have already acted in reliance upon the authorization.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature

If you are signing as a personal representative of the patient or are giving consent to disclose any treatment information for your personal care, please describe your relationship to the patient and/or source of your authority to sign this form:

Relationship to Patient

Patient Name (Print)