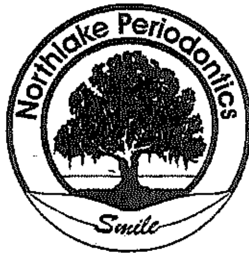

Marija G. LaSalle, D.D.S.
Practice Limited to Periodontics

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Authorization to Release Dental Treatment Information and Radiographs

Patient's name: ______________________________ Date of Birth______________

SSN: ______________________________

Doctor's name: ______________________________

Practice name: ______________________________

I request and authorize the above listed doctor and practice to release health care information of the patient named above to:

Name: ______________________________

Address: ______________________________

City, State: ______________________________Zip code: ______________

This request and authorization applies to dental care information relating to the following treatment, condition or dates of treatment:

____

Or: All dental care information
Or ______________________________

Other: ______________________________

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. This cancellation must be in writing and contain my name, request to cancel, date, and signature of myself or my authorized representative.

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

____
Signature of patient or patient's authorized representative Date

____
Relationship or status if signed by parent, legal guardian, personal representative, etc.