CHANDLER
Family Dentistry

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Warsaw, Virginia 22572
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*Asterick indicates required information.

AUTHORIZATION TO RELEASE DENTAL/HEALTH CARE INFORMATION

I request and authorize the doctor listed below and practice to release dental/health care records on the following patient to Chandler Family Dentistry/Dr. Irina Chandler, DDS.

*Patient's Name: _____ *Date of Birth: _ _/_ _/_ _ _ _

Other Names for Patient: _____

*Doctor's Name: _____

Name of Practice: _____ Phone: _____

Address: _____

*City: _____ *State: _____ *Zip Code: _____

This request and authorization apply to dental/health care records relating to the following treatment, condition, or dates of treatment: _____

_____

_____

or _____ All Dental/Health Care Information

or _____ Other: _____

_____

THIS AUTHORIZATION EXPIRES ON: _____

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.

There are two ways to cancel this agreement:

- Sign and date a form available from the Doctor or Practice called "Revocation of Authorization for Use and Disclosure of Health Care Information."
- Write a letter to the Doctor or Practice. If I write a letter, it must say that I want to cancel my authorization to disclose my Health Care Information. I (or my authorized representative) must sign and date the letter.

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.: _____