Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself.

I, _____ authorize the following person(s) to have access to information obtained by Word of Mouth Family Dentistry regarding my treatment, payment and healthcare operations, covered under the Privacy Act regarding myself.

_____

{Please Print Name} Relationship

_____

{Please Print Name} Relationship

_____

{Please Print Name} Relationship

Comments (if any):

Print Name: _____

Sign: _____

Date: _____