Chastain
DENTAL STUDIO

# Medical Release & Authorization Form

**Name:** _____ **Date of Birth:** _____

[ ] I authorize the release/disclosure of any and all information including any and all contents of dental record, including diagnosis, treatment, prognosis, financial, billing, and insurance information.

**This information may be released to (Mark one):**

[ ] **Spouse/Significant Other** _____

[ ] **Child(ren)** _____

[ ] **Other**_____

[ ] **Information is not to be released to anyone.**

The purpose of this request to release and/or disclose the PHI described above is for personal reasons. I understand that I have the right to revoke this Authorization, in writing, at any time by notifying the office above. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule.

I understand that my health care provider cannot condition treatment on whether I sign this Authorization. However, if I refuse to sign this Authorization, I understand that I will be financially responsible for any dental work provided by this office and will be responsible for filing any claims with my dental insurance company.

This Authorization will expire at such time that:

___ I decide to revoke this Authorization in writing; OR

___ The following date: _____ (within one year of current date).

**Preference on Leaving a Message**

Please call (circle one or more): **HOME** **WORK** **CELL**

If unable to reach me (mark one):

[ ] please leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day)_____ between (time)_____

I understand that this office will try to accommodate my wishes about my contact information, but may have to contact me at the other numbers if unable to contact me at my requested number/location.

**Signed**: _____ **Date**: _____