AUTHORIZATION FOR RELEASE
PROTECTED HEALTH INFORMATION

MINSTER DENTAL CARE

PATIENT DEMOGRAPHIC:

PATIENT NAME: FIRST - MIDDLE INITIAL - LAST _____ DATE OF BIRTH _____

MAILING ADDRESS _____ CITY _____ ZIP _____

HOME PHONE NUMBER _____ CELL PHONE NUMBER _____

PATIENT SOCIAL SECURITY NUMBER _____ EMAIL ADDRESS _____

INFORMATION RELEASED / EXCHANGED TO:

NAME / FACILITY / ORGANIZATION _____

MAILING ADDRESS _____ CITY _____ ZIP _____

PHONE NUMBER _____ FAX NUMBER _____

INFORMATION MAY BE RELEASED BY: □ Mail □ Fax □ Email □ In Person □ Other: _____

INFORMATION BEING RELEASED:

□ Entire Dental Record
□ Periapicals
□ Bitewing Radiographs
□ Panorex
□ Full Mouth Series
□ Dental Treatment Notes
□ Medical History Form (*including substance use and/or mental health diagnosis*)

DATES OF SERVICE: _____

PURPOSE AND NEED FOR INFORMATION:

□ Medical Care □ Insurance □ Disability/SSI □ Personal □ Attorney/Legal □ Other: _____

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MINSTER DENTAL CARE

AUTHORIZATION:

This form authorizes Minster Dental Care, Inc. to use and/or disclose protected health information in the manner described and is voluntary. Minster Dental Care, Inc. will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used or disclosed as a result of this Authorization may be subject to redisclosure by the person or entity receiving such information, and no longer portected by the federal privacy regulations.

I, the undersigned, hereby authorize Minster Dental Care, Inc. to use and/or disclose information from my (or give relationship) _____ medical records as specified. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s).

This authorization (unless revoked earlier) expires to itself in one year from this date: _____
TODAY'S DATE

_____ _____
SIGNATURE OF PATIENT (IF 18 YEARS OR OLDER) DATE

_____ _____
AUTHORIZING SIGNATURE IF THE PATIENT IS A MINOR DATE

_____
RELATIONSHIP TO THE PATIENT

IN OFFICE USE ONLY:

_____ _____
MINSTER DENTAL CARE TEAM MEMBER WITNESS DATE

REQUEST COMPLETED BY: _____ _____
TEAM MEMBER INITIALS DATE