LANG & MILLWARD DENTISTRY

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize **Lang & Millward Dentistry** to release health information identifying me under the following terms and conditions:

1. **Detailed description** of the information to be released: X-rays, doctor treatment notes if needed, periodontal charting etc.

2. **To whom** may the information be released (name(s) or class(es) of recipients): Practices may include but are not limited to; Oral Surgery, Periodontics, Endodontics, Orthodontics or General Dentistry.

3. **The purpose(s)** for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual): Patient referral to specialists that include but are not limited to: Oral Surgery, Periodontics, Endodontics, Orthodontics or General Dentistry.

4. Expiration date or event relating to the individual or purpose for the release: Referral to specialist for treatment purposes.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke authorization, send us a written or electronic note telling us that your authorization is revoked.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Signature:_____Date:_____
Patient, parent or legal guardian

If signed by patient representative, state relationship to patient:_____

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