WESTSIDE FAMILY DENTISTRY, PLLC
2300 Buffalo Rd Bldg 800A
Rochester, NY 14624
(585) 247-1530
wfdentistry14624@gmail.com

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name _____

Patient Address _____

Patient Telephone Number _____

I authorize the professional office of my dentist named above to release health information identifying me under the following terms and conditions:

1. Detailed description of the information to be released: *Information on dental treatment or medical information concerning public health*
2. To whom may the information be released [name(s) or class(es) of recipients: *Dental insurance companies, consulting physicians or dentists or public health officials if needed.*
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): *To provide proper dental care, facilitate insurance payment or comply with public health laws and statutes.*
4. Expiration date or event relating to the individual or purpose for the release: *None*

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 your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

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.

Patient Signature _____Date _____

If you want someone to have access to your dental treatment or appointment information please write

their name(s) here: _____

(If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form)

Relationship to Patient _____ Print Name _____

Source of Authority _____

PRINT