

AUTHORIZATION FOR THE RELEASE OF DENTAL INFORMATION

I authorize Boynton Health Service to release to: _____

Address: _____

I authorize _____

Address: _____

to release to Boynton Health Service, 410 Church Street SE, Minneapolis, MN 55455

information regarding: _____
(what information, i.e. clinic notes, x-rays, etc.)

to be used for _____
(continuing care, completing a form, etc.)

PATIENT IDENTIFYING INFORMATION

Name (Please Print) _____ Birthdate ____ / ____ / ____

Student ID #: _____ Boynton Medical Record #: _____

Address: _____

Telephone - Home: ____ (____) _____ Work: ____ (____) _____

- I understand that I may revoke this authorization by written request at any time to the address at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire one year from the date of my signature.
- I understand that once information is released pursuant to this authorization, Boynton Health Service cannot prevent the re-disclosure of the information to another third party.
- I understand there may be a charge associated with the release of information services rendered. There is no charge for release of information to other health care facilities for continuing care.
- Your treatment will not be conditioned on your signing this authorization except for research-related treatment.
- You are entitled to a copy of this *Authorization for the Release of Dental Information*.

Signature of Patient/Authorized Person
(If authorized person signing, also print name.)

Authorized Person's authority to sign
(Parent, guardian, power of atty., etc.)

Date

REASON PATIENT IS UNABLE TO SIGN: Minor Deceased Other _____

PLEASE CHECK ONE: I or _____ (valid picture ID required) will pick up the information at Boynton.

Mail the information to the address at the top of the page.

Charge/Fee: _____

OFFICE USE ONLY
Completed by: _____ Date Mailed: _____