



## Authorization to Release Health Information

### Patient Information:

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone \_\_\_\_\_

### At my request, Stellar Dental may release the following information:

- Entire record                       Financial records                       Office visit notes  
 X-Rays                               On site record review by the patient

### Entity or person who will receive the information:

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone \_\_\_\_\_

**Send the information electronically. Email address:** \_\_\_\_\_

For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

**This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.**

### Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority (attach necessary documentation)