BASS RIVER
DENTAL

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH OF INFORMATION

Patient Name (printed):

_____

Address:

_____

Phone number: Social Security Number:

_____

Date of Birth: Other Names Used:

I hereby authorize _____ to release information from my health record to:

Name and/or organization:_____

Address: _____ Phone Number_____

This authorization covers the following records:

☐ ALL RECORDS

☐ X-rays Only

☐ X-rays from _____ to _____

☐ My record for the treatment of _____ (please specify)

☐ My record for treatment received for the following time period: from _____ to _____

I authorize the release of this information for the following reason:

☐ Transfer of care to another practice

☐ Other (please specify): _____

- This authorization is valid for this request only and will not be honored for any subsequent request.
- This authorization for disclosure (unless expressly revoked earlier) expires after ninety (90) days.
- I understand that I can revoke this authorization at any time by making a request in writing to the Office Manager.
- I hereby acknowledge that I have read, or have had read to me, and fully understand the above statements as they apply to me and do voluntarily consent to disclosure.
- Please fax this form back to (508) 398-4793 or mail to Bass River Dental, 249 Station Ave, South Yarmouth MA, 02664
- A nominal fee no greater than $25 may be charged for a copy of your dental records

_____

Patient's signature or if authorized agent signature, please specify relationship Date

_____

Witness signature Date