AUTHORIZATION FOR RELEASES OF INFORMATION

Patient Name: _____

Last Name First Middle

_____

Maiden Name Previously Married Name D/O/B

I hereby request and authorize:

Name: _____

Address: _____

City: _____ State: _____ Zip : _____

Phone: _____

To send a copy of the following reports from the patient's record:

X-rays Perio Charting Full Dental Records

To be released:

Dr. Michael Shipp, DMD
Bristol Heights Dental
6085 N. Eagle Road
Boise, ID 83713

Electronic Records may be sent to:

info@bristolheightsdental.com

I acknowledge that data to be released MAY INCLUDE material that is protected by Federal Law that is applicable to ANY and ALL of the above.

My signature below authorizes release of all such information.

_____ _____

Signature of patient or responsible party Date

_____

Witness

I, the above signed, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent will expire upon completion of the transaction and no later than ninety (90) days from the date signed, unless otherwise stated herein.

To the party receiving this information: This information has been disclosed to you from the records, whose confidentiality is protected by Federal and/or State regulations prohibiting you make further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.