SMILEY DENTAL GROUP

SMILEY · HOLOWICKI

CONSENT FOR RELEASE OF INFORMATION

I authorize Smiley Dental Group to disclose my information to a third party recipient, such as a spouse, parent, significant other etc., as I designate below. **If the form is not completed in its entirety, the requested information will not be disclosed to the recipient identified.** This authorization is in compliance with Federal privacy regulations including the U. S. Department of Health and Human Services Privacy Rule.

I authorize:

Name:	Address:	Relationship to Patient:
_____	_____	_____
_____	_____	_____
_____	_____	_____

To receive information on the following: **Please check all that apply**

- ◯ Information related to my dental/medical treatment
- ◯ Information related to payment of my dental/medical treatment and/or claims

◯ I **do not** give authorization for my information to be disclosed.

_____ _____

Patient's Name Patient's Date of Birth

_____ _____

(Signature of person giving consent) Current mailing address

_____ _____

(Print name of person giving consent) Date

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