



STEDDUM

FAMILY & RESTORATIVE
DENTISTRY

Release of Information Authorization

Patient Information

Patient name: _____ DOB: _____

Authorization for Electronic Release of Information Disclosure

I hereby authorize Steddum Family & Restorative Dentistry (the Practice) to contact and disclose protected health information electronically to me via the following methods. My release of information may include patient registration information, medical and dental history, examination records, radiographs, clinical photographs, treatment plans, treatment records, referral and consultation recommendations and reports, diagnostic models and other related materials.

Select authorized contact methods:

☐ Mobile Phone and Voicemail Phone Number: _____

☐ Home Phone and Voicemail Phone Number: _____

☐ eMail eMail Address: _____

Protected Health Information Release to Additional Individuals

At my discretion, I may authorize the Practice to release protected health information about myself (or my minor child) as named above, to the additional individual named below. I may specify the name of the individual, how they should be contacted, and what information may be disclosed.

This authorization shall remain in effect until revoked. I understand that I have the right to revoke with authorization at any time by contacting the office to express such intent and completing a new form. I understand that a revocation is not retroactive when information has already been disclosed but will be effective on the date of the superseding form. I understand that information disclosed as a result of this authorization may be misused by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned by signing.

Optionally, I authorize these individuals to receive my information:

Name: _____ Phone Number: _____ eMail: _____

The person above is authorized to discuss: ☐ Scheduling Information ☐ Billing Information ☐ Test Results

Name: _____ Phone Number: _____ eMail: _____

The person above is authorized to discuss: ☐ Scheduling Information ☐ Billing Information ☐ Test Results

Name: _____ Phone Number: _____ eMail: _____

The person above is authorized to discuss: ☐ Scheduling Information ☐ Billing Information ☐ Test Results

Patient Name or Legal Representative (Print)

Signature of Patient or Legal Representative

Date