Pediatric Dentistry
OF KELLER

Patient Authorization
Release of Protected Health Information Records

Information to Be Released

Information covered by this authorization includes: _____

_____

Release of Records

The information listed above will be released to:

_____

Name of person, organization and address or fax number to which records should be sent - Please double-check fax number for accuracy

_____

Purpose of this Release

☐ For treatment at the facility to which records are sent ☐ Other reason _____

The Protected Health Information specified in this Release will be used solely for the purposes of treatment, payment and healthcare operations. Our facility complies with all applicable Federal and State privacy laws.

By my signature below I give permission to release the specified information.

Patient or Legally Authorized Individual Signature

Date Time

Print Patient's Full Name _____

Witness Signature

Date Time