

Authorization to Discuss Patient Records and Patient Identity

Patient Name: _____ DOB: _____

Concerning my right to confidentiality, I, as either the patient or patient's representative hereby authorize Dr Andrew Mancin at which treatment and care was provided, to release the information indicated to the persons identified below:

Name: _____

Phone: _____ Email: _____

Name: _____

Phone: _____ Email: _____

Name: _____

Phone: _____ Email: _____

Information to be released:

Patient name Patient finance amount Patient chart and records Patient radiographs

Other: _____

I understand that I may revoke this consent to release of information at any time. However I also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization to release information shall expire:

(1 YEAR FROM TODAY'S DATE)

PATIENT NAME

PATIENT REPRESENTATIVE NAME

PATIENT SIGNATURE

PATIENT REPRESENTATIVE SIGNATURE

DATE

DATE