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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: Date of Birth: [DOB]

Previous Name: Social Security #:

I request and authorize Emerson Dental, PC to release healthcare information of the patient named above to:

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates
- All healthcare information
- Other

[Additional information]

- Yes
- No

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date signed: [Date]

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED UNLESS OTHERWISE STATED