PALMER DENTAL ASSOCIATES, PC

2710 WILLIAM PENN HIGHWAY

EASTON, PA 18045

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name:____

I authorize the professional office of my dentist named above to release health information identifying me under the following terms and conditions:

1. Any situation that requires us to release information about your health as required by us due to the state law of Pennsylvania

2. If you have to take medication prior to appointment, may we leave a message on your machine?
YES_____ NO_____

If you sign this authorization, you may revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, you must send a letter to us or electronic note stating that your authorization is revoked. Correspondence must be sent to the address above.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. At times, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING THIS VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED ABOVE.

Patient Signature:____ Date:______________

I DECLINE THIS RELEASE/PATIENT SIGNATURE:_________________________________

Personal Representative Signature (if needed):_____________________________

Relationship to Patient:____