COMPLETE DENTISTRY
OF MIDLAND

Medical Release Form

Name of Patient: ______________________________ **Date of Birth:** __________________

Complete Dentistry of Midland and Dr. Diana Millard are authorized to release protected health information about the above-named patient to the entities named below. The purpose is to inform the patient or approved others of the patient's financial and/or treatment information.

Entity to Receive Information Confirm each entity that you approve to receive information	**Information to be Released** Check each that can be given to the entity
Voicemail (Yes/No)	• Financial Information • Treatment Information
Spouse (If yes, please provide name)	• Financial Information • Treatment Information
Parent (If yes, please provide name)	• Financial Information • Treatment Information
Other (If yes, please provide name)	• Financial Information • Treatment Information

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed because of this authorization may be subject to redisclosure 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 on signing. This authorization shall be in effect until revoked by the patient.

____Date________________

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)