Authorization to Release Health Care Information

Patient's name: _____ Date of birth: _____

Doctor's Name _____

Practice Name: _____

I request and authorize the above listed doctor and practice to release health care information of the patient named above to:

Corning Dental Associates RLLP
218 Denison Pkwy. E., Suite 201
Corning, New York 14830-2813
Phone - (607) 937-5341
Fax - (607) 937-5344

Digital radiographs and electronic records may be emailed to:
cdapr@stny.rr.com

This request and authorization applies to health care information relating to the following treatment, condition, or dates of treatment:

Dental Radiographs and Records

THIS AUTHORIZATION EXPIRES ON _____ or _____DAYS AFTER THE DATE IT IS SIGNED; or WHEN THE FOLLOWING EVENT OCCURS _____
_____

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement. I can:

- Sign and date a form available from the doctor or practice called "Revocation of Authorization for Use and Disclosure of Health Care Information" or

- Write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter.

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

_____
Signature of patient or patient's authorized representative Date signed

_____
Relationship or status if signed by parent, legal guardian, personal representative, etc.