AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: DOB:
ADDRESS:
CITY, STATE ZIP:

AUTHORIZE: RELEASE RECORDS TO:

Bailey Family Dental, S.C.
557 Cottonwood Avenue
Hartland, WI 53029

INFORMATION TO BE RELEASED:

__ Medical History
__ Treatment Notes
__ X-rays DATE:_____ ___ Prescriptions
__ Allergy Records __ Other (Specify): _____
__ Entire Record _____

A fee of $1.00 per page is charged for the production of a patient's entire paper record.
X-ray duplication fee is $2.00 per x-ray which is payable at time x-rays are picked up in the office.
Fee is waived one time if X-rays are transferred to another office via email.

PURPOSE OF DISCLOSURE: (Check applicable categories)

__ Further Medical Care ___Personal
__ Application for Insurance ___Changing Dentist
__ Legal Investigation ___Other (Specify_____

This authorization will remain in effect until: _____ Date

THIS AUTHORIZATION WILL BE EFFECTIVE FOR MEDICAL RECORDS GENERATED TO THE DATE OF SIGNATURE.

I UNDERSTAND I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY PROVIDING MY WRITTEN REVOCATION.

_____ _____
Signature of Patient Date
(If signed by person other than patient, state relationship to patient)

Patient is: ____Minor ____Incompetent ____ Deceased
Legal Authority: ____Parent or Legal Guardian ____ Next of Kin of Deceased ____Power of Attorney for Healthcare
____Legal Authorized Representative ____Executor of Estate of Deceased

This release is executed in conformity with Wis. Stats. §§ 146.81-.83, 51.30, 252.15