AUTHORIZATION FOR RELEASE OF MEDICAL/DENTAL INFORMATION

Print Name: _____
(Please Print) Last First M/I

Date of Birth: _____ Social Security Number (last four digits): _____

Address: _____
Phone Number: (____) _____ - _____
Treatment Date(s): _____

Please Release Medical Information to the Following Recipient:
Name of Person or Organization: _____
Phone Number: _____
Address: _____
_____
_____
Fax: _____

Purpose of Disclosure: ☐ at the patient's request

Description of Information to be Released:

☐ Registration Form	☐ Clinical Notes	☐ Correspondence
☐ Health History	☐ Radiographs	☐ Entire Record
☐ Dental History	☐ Photographs	

☐ Other: _____

I, the undersigned, authorize Drs. Esposito, Ostrowski & Whitmyer, LLC and its employees to release information from my medica/dentall records as described above. I understand and acknowledge that the medical/dental record may contain information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependency/abuse. I also understand that information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my information not being released.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Drs. Esposito, Ostrowski & Whitmyer, LLC. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.
If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my failure to sign this authorization.

I understand there may be charges for the copying and release of information and accept financial responsibility.

x_____

_____
Date Signed