NELSON BURY DENTISTRY

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ authorize Nelson & Bury Dentistry to release information to a third party recipient, such as a spouse, parent, significant other etc., as I designate below. If the form is not completed in its entirety, the requested information will not be disclosed to the recipient identified. This authorization is in compliance with Federal privacy regulations including the U. S. Department of Health and Human Services Privacy Rule.

I authorize:

Name:	Address:	Relationship to Patient:
_____	_____	_____
_____	_____	_____
_____	_____	_____

To receive information on the following: Please check all that apply

◯ Information related to my dental treatment

◯ Information related to payment of my dental treatment and/or claims

◯ I do not give authorization for my information to be disclosed.

_____ _____

Patient Name Date of Birth

_____ _____

Signature Date