

Authorization to Release Health Care Information

Patient's name: _____ Date of birth: _____

SSN: _____ Previous name: _____

I request and authorize **R. Bruce Robinson, Jr., D.D.S.** to release health care information of the patient named above to:

Name _____

Address _____

City, State _____ Zip _____

This request and authorization applies to dental care during the period _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

Signature of patient or patient's authorized representative

Date signed

Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED.

10/02