Authorization for the Release of Dental Records

Diana Brawka, D.D.S., PC

I hereby authorize _____, DDS to release the information in the dental record of

_____.

To:

Any and all information may be release including, but not limited to, mental health records, drug and/or alcohol abuse records which are protected by state or federal law, and/or HIV test results, if any, except as specifically provided below.

_____

_____

This authorization is effective now and will remain in effect until _____(date).

I understand I may receive a copy of this authorization.

_____

Signature Date

If not signed by the patient, please indicate relationship:

- Parent/guardian of minor patient
- Guardian/conservator of an incompetent patient
- Beneficiary/personal representative of deceased patient

_____

Relationship