KENTUCKY DENTAL GROUP
540 EAST MAIN ST.
LEXINGTON, KY 40508

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient____Date of Birth____________________

Dr. Weaver and Williams are authorized to release protected health information about the above patient to the entities named below.

Entity to Receive Information: Check each person/entity that you approve to receive information.

[ ] Voice Mail

[ ] Spouse (provide name)____

[ ] Parent (provide name)____

[ ] Child(ren) (provide name)____

[ ] Other (provider name)____

Patient Information: I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be used or disclosed. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. <u>THIS AUTHORIZATION SHALL BE IN EFFECT UNTIL REVOKED BY THE PATIENT.</u>

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Signature of Patient or Personal Representative   Date

Description of Personal Representative's Authority (attach necessary documentation)________________
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