

WILLIAMS FAMILY DENTISTRY  
James E. Williams  
540 EAST MAIN ST.  
LEXINGTON, KY 40508

## AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Dr. Williams is 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. THIS AUTHORIZATION SHALL BE IN EFFECT UNTIL REVOKED BY THE PATIENT.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

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