Authorization for Release of Information

Patients Name:________________________ Date of Birth:______________ Age:_________

If you wish to permit us to share any treatment and/or financial information to others, you must complete this authorization form. Signing this form will only give those indicated access to your information:

I authorize Ekim Orthodontics to release treatment and/or billing information to the following individual(s):

1 ________________________________Relation to Patient: ____________________________

2________________________________ Relation to Patient: ____________________________

3________________________________ Relation to Patient: ____________________________

4________________________________ Relation to Patient: ____________________________

I understand I have the right to revoke this authorization at any time and must notify Ekim Orthodontics in writing.

I understand that I have the right to inspect or have a copy the protected health information to be disclosed.

I understand that information disclosed to any of the above individuals is no longer protected by federal or state law and may be subject to re disclosure by the above recipient.

Signature: ________________________________ Date: ________________________

Patient or parent/guardian if minor