Authorization for Release of Information

Name of Patient _____

Date of Birth _____

James A. Wells, DDS, PA is authorized to release protected information about the above named patient to the named entities below.

Please initial the statement approving release of information.

I approve discussing billing information with _____.

Notice to Parents: Please list all names and relationship of those who are approved to be involved in your child's health or financial care.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Rights of the Patient

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 disclosed as described in this document by sending a written notification to James A. Wells, DDS, PA.

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 condition on singing. 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)