Authorization for Lakemont Family Dentistry to Disclose my Health Information

Patient Name: _____ Date of Birth_____

My Authorization

☐ You may disclose current x-rays and periodontal charting in my dental chart

You may disclose the above information to:

Name of Organization: _____

Address:_____

Reason for record transfer:_____

Once Health care information is disclosed, the person or organization that receives iit may re-disclose. Privacy laws may no longer protect it.

_____ _____

Patient's signature Date