BERST DENTAL

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Patient's Date of Birth: _____
(please print)

Patient's Signature: _____ Date Signed: _____

I hereby authorize the use and disclosure of the patient information as described below. I understand that the information disclosed pursuant to this authorization might be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Specific description of the patient information to be used or disclosed (please circle all that applies)

Dental Treatment Insurance Appointments Account Balance

Purpose(s) of this use or disclosure: _____

The following person(s) may receive this patient information:

_____