Piedmont Dental @ Lake Anna
5205 Courthouse Road, Suite 201, Spotsylvania, VA 22551
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Authorization to Release Healthcare Information

Patient's Name: _____ Date of Birth: _____

SS# _____

I request and authorize Piedmont Dental @ Lake Anna to release healthcare information of the patient named above to:

Name/Office:_____

Address: _____

City/State/Zip Code: _____

This request and authorization applies to:

( ) Healthcare information relating to the following treatment, condition or dates as specified:_____

_____

_____

( ) All Healthcare Information

( ) Other: _____

_____

This Authorization is valid until:

( ) _____date/event ( ) One year from today's date ( ) indefinitely

_____ _____

Relationship to Patient Patient or Legal Guardian Name (Printed)

_____ _____

Patient or Legal Guardian (Signature) Date