Piedmont Dental @ Lake Anna

Authorization to Release Healthcare Information

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ SS#_____

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

Name: _____

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

_____ _____ _____

Patient or Legal Guardian Date Relationship to Patient