MAJOR DENTAL CLINICS
OF CHICAGO

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name:
Patient Address:
City, State, Zip:
Patient Phone Number:

I authorize Major Dental Clinics to release health information identifying me [including applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description

2. To whom may the information be released [name(s) or class(es) or recipients]:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office at info@majordentalclinics.com.

When your health information is disclosed as provided in this authorization, the receipt often has no legal duty to protect its confidentiality. In many cases the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTOOD THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated: _____ Patient Signature: _____