Thomas R. Fordiani, DDS

Patient Authorization to Release Health Care Information

I, _____, hereby authorize Thomas R. Fordiani, DDS to release health care information to:

Name, address, phone, email of Organization to use or receive the information:

_____
_____
_____

Information to be released: _____

_____

Purpose of release: _____

This authorization expires on _____.

This authorization shall be in force and effect until the above date, at which time it will expire. I understand that I have the right to revoke this authorization in writing at any time, or I can sign and date a form available from the practice called "Revocation of Authorization for Use and Disclosure of Health Care Information"

I understand a revocation does not effect health information already sent out under the Authorization and that there is a potential for my Protected Health Information to be re-disclosed by the recipient.

Printed Name of Patient/Guardian:_____

_____

Patient Signature **Date:**