I, _____, give Seacoast Dream Dentistry authorization to disclose and release my protected health and dental information described below to:

Name _____ Relationship _____

Contact Information

_____

_____

Health Information to be disclosed upon the request of the person named above

_____ Disclose my complete health and dental record (including but not limited to diagnoses, prognosis, treatment and billing)

OR

_____ Disclose my complete health and dental record, **BUT do not disclose** the following:

_____

_____

_____

This authorization shall be effective until:

_____ All past, present, and future periods

OR

_____ Date or event: _____

You may revoke this authorization in writing at any time by notifying Seacoast Dream Dentistry in writing.

_____ _____

Patient Name Date of Birth

_____ _____

Signature of Patient Date