# AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Compass Dental, LLC/ Charles R. Fana, Jr. DMD P.C. to release/receive the following information from the records of:

Patient Name: _____

SSN: _____DOB:_____

Address:_____

City:_____State:_____Zip:_____

Telephone Number:_____

Email:_____

**To be released to:**

Name:_____

Telephone Number:_____ Fax:_____

Email:_____

Address:_____

City:_____State:_____Zip:_____

Information to be released: (Circle all that apply)

Entire Record X-Rays

Other:_____

For dates of service rendered_____through_____

Records are to be released for the purpose of:_____

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I understand that I can revoke this authorization by providing written notice to the office manager of Compass Dental, LLC/ Charles R. Fana, Jr. DMD P.C. at the address listed above. I also understand that if the information has been released upon this Authorization, that revocation will not be valid.

**I PLACE NO LIMITATIONS ON THE RELEASE OF HISTORY OF ILLNESS OR DIAGNOSTIC OR TREATMENT INFORMATION, INCLUDING BUT NOT LIMITED TO ANY INFORMATION CONTAINED IN MY RECORD CONCERNING TREATMENT FOR ALCOHOL, DRUG ABUSE OR DEPENDENCY, MENTAL ILLNESS, PSYCHIATRIC OR PSYCHOLOGICAL ILLNESS OR AIDS.**

I understand that I am waiving my rights to privacy by releasing my information to the parties listed above and this information may be redisclosed to the receiving party. I understand that this Release will expire within ninety (90) days from the date listed below.

Patient Signature_____Date_____

Patient's Guardian_____

Relationship to Patient_____

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For Office Use Only:

Request completed by: _____

Method of Release: Mail Pick-Up Fax