Amanda B. Boltwood, D.D.S., P.L.L.C.
2490 Walton Blvd, Ste. 202
Rochester Hill, MI 48309
248-656-2244
Contact Persons: Kathy Barrett, Julia Smith

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name_____

Patient address _____

Patient phone number _____

I authorize the professional office of my dentist named above to release health information identifying me under the following terms and conditions:

For treatment, payment and health care operations, and for safety reasons.

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 contact person listed at the top of this form.

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

Date: _____ Patient Signature:_____

If you are signing as a personal representative of the patient, describe your relationship to the patient:

Relationship to Patient _____Print Name_____