AUTHORIZATION FOR RELEASE OF MEDICAL/DENTAL RECORDS

Patient's Name   Date

____/_____/_________
Patient's Birth Date

I hereby request and authorize the release of all information, without limitations, regarding any physical and mental condition, as revealed by your observation or treatment, past, present or future.

This includes photocopies of medical and/or dental histories, x-ray findings, diagnosis, treatment, prognosis and financial records.

I request that you release the above information to:

BRET A. AVRA, DMD
BRET A. AVRA, DMD, PSC
2605 Kentucky Ave., DOB #3, Suite 302
Paducah, KY 42003
(270) 443-1717
(270) 443-0517 Fax

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

To cancel this agreement:

- Write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter.

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

Patient's (or Legal Guardian's) Signature   Date

Witness' Signature   Date