LYON DENTAL IMPLANTS
AND ORAL SURGERY

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Release of Information

Patient name_____DOB: _____

☐ Please mark **FOR AUTHORIZATION TO RELEASE**
☐ Please mark for **DENIAL TO RELEASE INFORMATION**

Authorization:

I authorize Lyon Dental Implants and Oral Surgery (LDIOS), Dr. Gupta, and LDIOS employees to release the above-named individual's protected health information to:

NAME OF ALL PARTIES AUTHORIZED TO HAVE MY INFORMATION RELEASED TO:

_____

Relationship(s) to Patient: _____

Phone Number(s):_____

This allows for the sharing of the patient chart in a HIPAA-secure fashion and the discussion of the patient's case with the party the information is being released to (including both medical and financial discussions)

By signing this authorization, I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal privacy rules. I further understand *that I may request a copy of this signed authorization.*

Patient/Guardian signature: _____

Print name (if Guardian):_____

Date: _____