Office Hours By
Appointment Only

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Family & Cosmetic Dentistry, P.A.

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Authorization to Release Health Records Information

Patient's Name: _____ Soc. Sec. #_____

Telephone # _____ Date of Birth _____

I am the ☐ Patient ☐ Guardian ☐ Surrogate/Designee and hereby authorize Family & Cosmetic Dentistry, P.A to release health information for the above-named patient.

I am the ☐ Patient ☐ Guardian ☐ Surrogate/Designee and hereby authorize _____ to release health information for the above-named patient.

Send information to (*name of person, organization, or agency with full address*):

Name: _____

Attention: _____ Telephone # _____

Address/email: _____

City: _____ State: _____ Zip: _____

Purpose of release (*for example: continued care, personal, etc.*): _____

Specific items or dates needed: _____

This authorization is for release of dental records, radiographs and information including diagnosis, treatment, and/or examination related to mental health, drug and/or alcohol abuse, HIV testing/AIDS, and sexually transmitted diseases.

I understand that this authorization will remain in effect for one (1) year or until I revoke it in writing.

I hereby release Family & Cosmetic Dentistry, P.A, Bertram J. Hughes, D.M.D. and its employees from any and all liability that may arise from the release of information as I have directed.

I understand that I may be charged a fee of up to $1.00 per page (plus applicable tax and handling) for every page copied and up to $25 for the duplication of any x-rays. This fee may be waived for copies provided to a health care provider for continuing dental care. I understand that this fee is within the limits allowable by Florida law and is due before any records may be released.

Signature release: _____ Date: _____

Relationship to Patient: _____ **Please remit:** $ _____