LAWSON family dental

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Consent to Release Dental Information

Patient Name: ______________________________

Date of Birth: ____________ Phone #:____________________

I hereby authorize Lawson Family Dental to disclose to the following individual(s) all dental information on file, including but not limited to:

- entire dental record
- any insurance claim information
- any payment/billing/account information

______________________________ ____________________
Name Relationship

______________________________ ____________________
Name Relationship

______________________________ ____________________
Name Relationship

I understand that I have the right to receive a copy of this authorization. I understand that I can revoke all or part of this authorization at any time except for parts that were released before I revoked it. I understand that when my dental information is released, it will no longer be protected by Lawson Family Dental.

I also acknowledge that this Authorization is a One-Time Authorization Only. Any additional access to my dental records will require a new Authorization.

Signature of patient/Responsible party: ______________________________
Relationship to patient: ______________________ Date: ____________