AUTHORIZATION TO RELEASE INFORMATION

Patient Name:_____

Patient Address:_____

Patient SSN:_____

I HEREBY AUTHORIZE:

Name:_____
Address:_____
Phone/Fax:_____

to release my dental/medical records to:

Monrovia Family Dentistry
1920 Slaughter Road
Madison, AL 35758
Phone: 256-830-2095
Fax: 256-830-2021

I hereby authorize Monrovia Family Dentistry to release my dental/medical records to:

Name:_____

Address:_____

Phone:_____

Fax:_____

I understand that I am signing this authorization freely; that I may revoke this authorization at any time by providing written notice to the practice: that I may not revoke this authorization if the practice has already taken action utilizing this authorization; that the information disclosed in this authorization may be subject to redisclosure by the practice and no longer protected by federal law; and I understand the intent and use of this authorization. I also understand that I will be responsible for paying the fee to duplicate records ($8) and x-rays ($10)[1], due at the time of this request.

SIGNATURE:_____DATE:_____

[1] Alabama Code § 12-21-6.1.