AUTHORIZATION TO RELEASE CONFIDENTIAL PATIENT INFORMATION
CONSENT FORM AND NOTICE OF PRIVACY POLICIES

Patient name if minor child_____

I, _____ hereby request and authorize **BOREALIS DENTAL STUDIO** to disclose and provide copies of any and all clinical treatment records and information concerning my care, which is in the possession of this person or entity, to: (CAN BE FAMILY MEMBER, SPOUSE, ADULT CHILD, OR REPRESENTATIVE)

NAME:_____PHONE:_____

NAME:_____PHONE:_____

These records include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment plans, treatment records, referral and consultation recommendations and reports, diagnostic models, and other related materials.

I give **BOREALIS DENTAL STUDIO** permission to disclose my health information to a physician, dentist, laboratory technician, or other healthcare provider associated with providing treatment to me. I give permission to **BOREALIS DENTAL STUDIO** to request updated health information from these individuals (such as current radiographs, last exam and procedures done) to assist us in providing treatment for me.

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I also understand that I have the right to revoke permission.

I authorize **BOREALIS DENTAL STUDIO** to use and disclose medical information to contact me in regard to an appointment, possible treatment options, or other benefits or services that may be of interest to me**.** **BOREALIS DENTAL STUDIO** may call me and, if necessary leave messages on my answering machine.

I expressly release from liability the above named person or entity from any and all liability arising from compliance with this request and disclosure of the requested information.

SIGNED:_____ DATE:_____

Relationship to patient: Self Parent Guardian (Circle one)