## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name	Date of Birth	
Legal Guardia	n Date of Birth	
I request and authorize RTC Dental to release personal health information of the above patient to:		
	Name	
	Address	
	City/State/Zip	
We may also E-Mail X-Rays (if you can accept e-mail please indicate address)		
E-Mail Addres	ss	
	quest: Referral for specific purpose Second Opinion Transferring Providers Other	ease send indicated items:  X-rays Treatment records
This request and authorization applies to healthcare information relating to treatment and conditions. Pursuant to the Federal Law, this request must be fulfilled within 21 business days of request. There is a charge of \$ .65 per page plus any applicable postage fees for the duplication of records.		
	ion. I know that canceling this authorization would not pro-	that the doctor or practice may have already released information about shibit any release of information by the doctor or practice in reliance on
and Disclosure of Heal to disclose my healthca	theare Information" or write a letter to the doctor or practic	from the doctor or practice called "Revocation of Authorization for Use te. If I write a letter, it must say that I want to cancel my authorization pecific identification of the person(s) that I no longer want to receive
	out the information that I released, I know that my doctor have information might re-disclose it. Federal or State privacy	as no control over the information. The individual or organization that I aws may no longer protect the information.
Signature of patien	at or patient's authorized representative	Date
Relationship to pat	tient if signed by parent or representative	Patient's 18 years or older MUST sign their own form.