Authorization For Release Of Information

I, _____, give permission to **Alexander L. Gill, D.D.S., P.A.** to release my protected health information to the persons listed below:

_____ relationship to patient: _____
_____ relationship to patient: _____
_____ relationship to patient: _____

Description of information to be released:
(check all that apply):

- ☐ Dental/Medical Information
- ☐ Treatment Information
- ☐ Lab/Diagnostic Information
- ☐ Financial Information
- ☐ Family Billing Information
- ☐ Other: _____
  _____
  _____

I authorize the use of my:
(check all that apply):

- ☐ Home phone/voice mail
- ☐ Work phone/voice mail
- ☐ Cell phone/voice mail
  for appointment, treatment and financial information.

Rights Of The Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Alexander L. Gill, D.D.S., P.A., Attention: Privacy Officer. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in effect until revoked in writing by the patient or representative signing the authorization.

_____ Date _____
Signature of Patient or Personal Representative

_____
Description of Personal Representative's Authority (attach necessary documentation)