Authorization for Release of Information

Name of Patient _____ Date of Birth_____

____Dr. Susanne P. Jackson, DDS_____ is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Please check each entity that is authorized to receive information. This information includes: Information regarding treatment needs, treatment plans, and diagnosis. If needed, you may make notes on specific requests beside each entity you check.

- ☐ Voice Mail (only on numbers provided) _____
- ☐ Spouse/Significant Other (Provide Name) _____
- ☐ Parent/Guardian (Provide Name) _____
- ☐ Other (Provide Name and Relationship) _____
- ☐ No Authorization Given

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. 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 as a result of this authorization may be subject to disclosure 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 shall be in effect until revoked by the patient.

Signature of Patient or Personal Representative _____

Date _____