AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____ do hereby authorize
_____(name of practice that is to provide records)
to release to Dr. Susanne Jackson, D.D.S. and/or Dr. Tammy Samuelson, D.M.D.
my dental records including clinical records, copies of x-rays, and records of prescribed medication.

I understand that such information is confidential and is protected by federal law, regardless by signing this release I allow the production of these records to Dr. Susanne Jackson, D.D.S. and/or Dr. Tammy Samuelson, D.M.D. I acknowledge the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law.
Dr. Jackson and/or Dr. Samuelson will not condition my treatment (or any payment, enrollment in a health plan, or eligibility for benefits) on receiving my signature on this Authorization.

Charges for copies of all records furnished shall be billed to me. A photocopy of the original of this Authorization for Release of Medical Records shall be sufficient and acceptable to all persons and entities from whom these records are requested. The purpose for the requested disclosure is at the request of the undersigned individual for treatment purposes, and this Authorization shall be deemed to comply with all notice requirements of HIPAA, specifically 45 CFR §164.508.

This authorization shall expire:_____

I understand that I may revoke this Authorization at any time by sending written notice to Dr. Jackson or Dr. Samuelson.

_____	_____	_____
Date of Birth	Signature	Date

*Please email records to lisa@susannejacksondds.com
OR
Mail to Dr. Susanne Jackson and Dr. Tammy Samuelson
77 Vilcom Center Drive, Suite 180
Chapel Hill, NC 27514
Office Phone-919-968-9874 Office Fax-919-869-1335