Patricia Haberman DDS, PC
3951 Main Street
Eggerstville, NY 14226
716-836-5252

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name_____

Guardian(relationship):_____

Others to release information to: _____

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

Insurance payments, release of records to a specialist or your medical doctor, court subpoena and/or all other uses permitted by law.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Patricia Haberman DDS, PC Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____