Authorization to Release Health Care Information

Complete the appropriate forms online and send them to us prior to your visit at Best Smiles. This will help us make your visit as pleasant and efficient as possible.

Patient's Name *

First

Last

Date *

Address *

Street Address

City

State / Province / Region

ZIP / Postal Code

SSN *

The above named patient, request and authorize the below named dentist or dental practice to release my healthcare information to Jeane M Best, DDS, of Best Smiles LLC, 799 Farmington Avenue, West Hartford, CT 06119, fax 860-233-3294, office@bestsmileswesthartford.com.

Name of Dentist or Dental Practice *

Address *

Street Address

City

State / Province / Region

ZIP / Postal Code

The request and authorization applies to health care information relating to the following treatment, condition, or dates of treatment: *

THIS AUTHORIZATION EXPIRES 30 DAYS AFTER THIS RELEASE IS DATED, SIGNED, AND RECEIVED BY BEST SMILES, LLC.

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.In order to cancel this agreement, I understand that I must write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter.Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorize to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

Please Print and Sign Below by Hand

Signature of patient or patient's authorized representative / Date Signed

Relationship or status if signed by parent, legal guardian, personal representative, etc.

SUBMIT