PRO ENDO

Milos R Janicek, DMD Craig L Cedermark, DDS

PROFESSIONAL ENDODONTICS, LLC

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient full name: _____ Patient date of birth: _____

I authorize Professional Endodontics, LLC to release identifying health information under the following terms and conditions:

1. Care and services rendered at Professional Endodontics, LLC including but not limited to progress notes, treatment plans, radiographs, treatment, and follow-up care recommendations.
2. To the referring dentist(s): _____
3. To your dental insurance carrier in order to process any claims (if applicable): _____
4. The purpose of this release is to coordinate and communicate patient care between Professional Endodontics, LLC and the aforementioned parties.
5. If no expiration date is specified, this release will expire one year from the signature date.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it at a later date. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you would like to revoke your authorization, please send us a written or electronic note telling us that your authorization is revoked.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as they wish. Sometimes, state of federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THIS DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM

Date: _____ Patient Signature: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to patient: _____

Print name: _____

Source of authority: _____

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