CONSENT FOR RELEASE OF MEDICAL RECORDS USE
PLUS DISCLOSURE OF PROTECTED HEALTH INFORMATION TO A THIRD PARTY

Please complete this form and return to your previous dentist's office to release your current records. Your prompt attention will insure your records are transferred in time for your appointment.

______________________________ ______________
Patient's Full Name Birth Date

______________________________ ______________
Patient's Full Name Birth Date

______________________________ ______________
Patient's Full Name Birth Date

______________________________ ______________
Patient's Full Name Birth Date

______________________________ ______________

I ______________________________, grant permission to the dental office of ______________________ to release all medical records, x-rays, PHI, and test results of the listed patients above to:

Doctor/Office Name: EAST BAY FAMILY DENTISTRY

Street Address: 862 MUNSON AVE

TRAVERSE CITY MI
Email: eastbaydds@mytcsmiles.com

I release, hold harmless and agree to indemnify this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I consent to the method of release of my information stated above by verbal, mail, fax, encrypted or unencrypted email.

____ ____________________
Signature / Legal Guardian Date