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Authorization to Release Patient Information

I AUTHORIZE THE AXCEL DENTAL AND ITS EMPLOYEES TO RELEASE PROTECTED HEALTH INFORMATION ABOUT ME / MY CHILD TO THE RECIPIENT WHICH MAY INCLUDE BUT NOT LIMITED TO ALCOHOL AND DRUG ABUSE TREATMENT; PSYCHOLOGICAL AND SOCIAL WORK COUNSELING; HIV OR AIDS OR ARC; COMMUNICABLE DISEASE OR INFECTIONS, INCLUDING SEXUALLY TRANSMITTED DISEASES, VENEREAL DISEASE, TUBERCULOSIS AND HEPATITIS; AND DEMOGRAPHIC INFORMATION; FOR THE PURPOSES, AND UNDER THE CONDITIONS DESIGNATED ON THIS FORM.

PATIENT INFORMATION

First Name	Last Name		Date of Birth
Street Address	Citi	State	Zip Code
Phone Number	Email:		

SEND RECORDS TO: (Choose only ONE Delivery Option)

☐ SEND BY MAIL TO:
Self or Name of Dentist, Physician, Institution, Clinic, Etc.
Address City, State, Zip Code Phone Number

☐ SEND BY ENCRYPTED EMAIL TO:
Self or Name of Provider/Clinic Phone Number (E- Archived records may take two weeks to complete) mail

INFORMATION TO BE DISCLOSED:

- ☐ Recent x rays/ treatment notes
  (May take two business days to complete)
- ☐ Specific Information

PURPOSE(S) FOR DISCLOSING INFORMATION:

- ☐ Consultation
- ☐ Attorney Inquiry/Legal Matter
- ☐ Insurance Claim
- ☐ Other:
  _____

SIGNATURE: _____ DATE: _____

AUTHORIZATIONS SIGNED BY A LEGAL REPRESENTATIVE MUST INCLUDE A COPY OF THE GUARDIANSHIP PAPERS OR A POWER OF ATTORNEY.