THRIVE
DENTAL & ORTHODONTICS

Authorization for Release of Information

I _____hereby authorize Thrive Dental & Orthodontics to release
(print first/last name)
copies of any and all my dental records with respect of my dental care I received/receiving and or pending treatment to the following individuals (listed below):

_____ Relationship: _____
(print first/last name)
_____ Relationship: _____
(print first/last name)
_____ Relationship: _____
(print first/last name)

Release and or disclose the following records/information *(check below)*:

- ❏ Financial Records
- ❏ Discuss Dental Treatment Plan/Diagnosis
- ❏ All Records (Including not limited to X-Rays,Treatment Plan/Diagnosis, Financials, etc.)
- ❏ Other (Indicate Below):

_____
_____
_____

Disclose/Send To *(Organization Name, Address, Telephone/Fax)*:

_____
_____
_____

For the following purposes:

_____

I understand that the specific type of information to be disclosed includes a detailed report of examinations diagnosis, treatment planned and or services rendered, radiographs (x-rays) and all other records which pertain to the patient (me). I may revoke this authorization in writing at any time, except for information, which has already been released in accordance with this authorization prior to my revocation.

Patient Signature: _____ Date: _____

Signature of Parent/Legal Guardian: _____ Date: _____

Witness Signature/Initials: _____ Date: _____