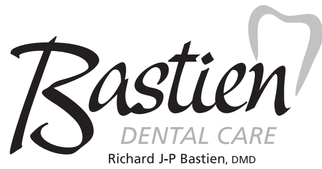

2621 Mitcham Drive • Suite 102 • Tallahassee, FL 32308
PHONE: 850-425-1300 • FAX: 850-219-1527
EMAIL: info@bastiendentalcare.com • www.BastienDentalCare.com

Authorization to Release Confidential Information

I ____

Patient of guardian name

hereby request and authorize Richard J-P Bastien, DMD to disclose and provide copies of any and all clinical treatment records and information concerning my care, which is in the possession of this person or entity, to:

____

Name of new dentist

____

Address

____

City State ZIP Telephone Number

These records include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment plans, treatment records, referral and consultation recommendations and reports, diagnostic models, and other related materials.

I expressly release from liability the above named person or entity from any and all liability arising from compliance with this request and disclosure of the requested information.

I reserve the right to:

- ➢ **Revoke this authorization in writing by submitting it to the attention of your Privacy Officer;**
- ➢ **Inspect or copy the protected health information to be used or disclosed;**

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA.

______________________ ______________________

Print Patient Name Relationship (if other than patient)

____

Signature

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