AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _				
	Last	First	MI	Maiden or Other Name
Date of Birth:	-	Phone:		
Check appropri	ate box:			
	ovidence Oral Surgery to eatment, payment and he	use and disclose my protecte alth care operations.	ed health infor	mation for his/her own
a. a)	ovidence Oral Surgery to o Medical Records Treatment Records Billing and Claims Record	disclose the following records	S:	
Who can we disc	close information to (this o	does not include corresponde	ence to other	dental offices)?
Name:		Name:		
Relationship:		Relationship):	
Patient Name (Pr	rinted):			
Patient Signature	: :	Date:	_	_