Green Hills
DENTAL GROUP
John L. Farringer III, D.D.S.

Authorization for Disclosure of Health Care Information

Patient Name: _____ Date of Birth:_____

You may disclose the following health care information: (check all that apply)

□ All health care information in my medical record

□ Health care information in my medical record relating to the following treatment or condition:_____

□ Health care information in my medical record for the date(s): _____

□ Other (e.g., X-rays, bills, specify date(s):_____

You may disclose this health information to:

Name: _____
Address: _____
_____

□ **I do not wish to have my health care information disclosed to anyone**

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Printed Name Relationship to Patient