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Lifetime Dental Care
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Patient's name________________________________ Date of birth__________________

SSN/ID#___________________________ Previous name_________________________

I request and authorize _________________________ to release the following healthcare information of the above named patient to:

Office name:____
Address:____
City, State:___________________________________ Zip Code:________
Phone:____

This request and authorization applies to:

( ) Health care information relating to the following treatment, condition, or dates of treatment.

____

____

( ) All health care information

( ) Other

____

____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

____

Signature of patient of patient's authorized representative Date signed

____

Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative etc.)

This form expires 90 days after the date it is signed