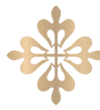

ARLINGTON ADVANCED DENTISTRY

DEDICATED TO EXCELLENCE

Authorization for Release of Information

PATIENT INFORMATION

Name: Birthdate:

Mailing Address:

Phone #: Email:

REQUESTED FROM

Doctor/Office Name:

Mailing Address:

Phone #: Email:

RELEASE TO

- ☐ Dr. Springer
- ☐ Dr. Rubinstein
- ☐ Dr. Czapek

Arlington Advanced Dentistry
1845 E. Rand Road, Suite 200
Arlington Heights, IL 60004
847-870-8820 · info@arlingtonadvanceddentistry.com

Records may include and are not limited to personal patient information, medical and dental history, examinations, radiographs, treatment plans, referral and consultation recommendations and reports, diagnostic models, and other related materials for the following purpose:

- ☐ Continuation of Care
- ☐ Personal Records
- ☐ Insurance
- ☐ Legal
- ☐ Other (specify): ______________________

Release of records is voluntary and may be revoked at any time by submitting a written request to the releasing individual/agency. The revocation will not apply to any information that has already been released in response to the original request. The requestor has the right to inspect or obtain a copy of the information. Receiver(s) of information may not be subject to federal health information privacy laws and information may no longer be protected. Any disclosure of information carries the potential for unauthorized redisclosure.

I, the patient and requestor, have read the above foregoing Authorization for Release of Information and do hereby authorize the disclosure and/or use of my health information as described above. I am familiar with and fully understand the terms and conditions of this authorization.

Signature: ____ Date: ________________