

Gentle Dental Care of NMB, P.C.  
1004 Sea Mountain Hwy  
North Myrtle Beach, SC 29582  
Dr. John P. Finucane

## AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize the professional office of my dentist to release the health information identifying me (including if applicable, information about HIV infections or aids, information about substance abuse treatment, and information about mental health services) under the following terms and conditions.

- Detailed description of the information to be released
- To whom may the information be released
- The purpose(s) for the release (if the authorization is initialed by the individual permissible to state at the request of the individual as the purpose, if desired by the individual)
- Expiration date or event relating to the individual or purpose for the release

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you may revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written note telling us that your authorization has been revoked. Send this to the office contact person listed at the top of this page.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect it's confidentiality. In many cases, the federal law changes this possibility.

I have read and understand this form. I am signing it voluntarily, I authorize the disclosure of my health information as described in this form.

Patient Signature: \_\_\_\_\_

Date \_\_\_\_\_

Relationship: \_\_\_\_\_