KEVIN S. BREWER, D.M.D.
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AUTHORIZATION FOR RELEASE OF INFORMATION

NAME_______________________________SSN_________________DOB______________

I. General Release
I hereby authorize ______________________________ to disclose specifically the following
(previous dentist name)
information in Section IV for the following date range: initial visit to current history**.** I further authorize - above named doctor upon presentation of this authorization or a copy thereof, to
photocopy such records as are reasonably necessary for the stated purpose(s) in Section II (d.)
II. Dental / Health Information Release
I hereby authorize the disclosure of my dental/health information, as described in this authorization:
a. Person(s) authorized to disclose the information: ____________________________________
(previous dentist name)
b. Information to be disclosed: The information set forth in Section IV of this authorization. (I understand that this may include dental/health information pertaining to treatment of drug and alcohol abuse, mental health including without limitation psychiatric information, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, sickle cell anemia treatment, tuberculosis information or genetic information.

c. Person(s) authorized to receive this information: Kevin S. Brewer, D.M.D.

d. Purpose of this request: ____
e. This authorization will expire one year after the date of authorization or later if indicated here:_______
f. Right to revoke: I understand that I have the right to revoke this authorization at any time by notifying in writing each Person identified in Section (a). I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
g. Subsequent Disclosure: I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
h. Impact on Dental/Medical Treatment: I understand that I do not need to sign this authorization to assure dental/medical treatment. I understand that I may inspect the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have questions about disclosure of my health or dental information, I may contact the privacy officer for each Person identified in Section (a).
III. Signature/Certification:
X____ **Date**_____________
By signing this authorization, the Authorized Representative/Guardian warrants that he or she has the authority to act on behalf of the person identified above based on:________________________________.

IV. Information Subject to the Dental/Health Information Release.
_______ All Dental/Medical Records (electronic and paper) relating to my treatment, including but not limited to x-rays, daily office notes, progress notes, clinical records, documents, correspondence, conversations, records of telephone conversations, and records received from other providers.