☐ Patient or Patient Representative refused to sign/complete this document

Release Of Medical Information

I understand that my health information may be used or disclosed for the purposes of treatment, payment, and operations in accordance with state and federal regulations for privacy and security. I understand that this may include disclosures of information to my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I give Upstate Family Dental permission to disclose to a relative or friend my location and general condition, or other information directly relevant to that person's involvement in my care, to those I have named below:

- ○ Primary Care
- ○ Dental Care
- ○ Specialty Care:_____
- ○ **All information**

_____ _____

(First and last name) *(Relationship to patient)*

- ○ Primary Care
- ○ Dental Care
- ○ Specialty Care:_____
- ○ **All information**

_____ _____

(First and last name) *(Relationship to patient)*

- ○ Primary Care
- ○ Dental Care
- ○ Specialty Care:_____
- ○ **All information**

_____ _____

(First and last name) *(Relationship to patient)*

- ○ Primary Care
- ○ Dental Care
- ○ Specialty Care:_____
- ○ **All information**

_____ _____

(First and last name) *(Relationship to patient)*

Please note: this document **does not expire** and is considered to be in effect unless the patient/personal representative updates or revokes it in writing. Furthermore, this document only applies to medical-related information and does not include the release of dental information

_____ _____ _____

Signature of Patient or Representative Authorized by Law *Patient Name* *Date*