TURNAGAIN DENTAL
David Green, D.D.S., L.L.C
1842 W. Northern Lights Blvd.
Anchorage, AK 99517
PHONE: (907)272-6122 FAX: (907)274-0442

Authorization to Release Information

Patient Name(s): ____Telephone: ______________________

Address: ____

City: ___________________________________ State: ____________ Zip: _______________________

Print Name of Parent/Guardian (if request is for a minor): ______________________________________

Information Requested/Released:

( ) Evaluation & Treatment Plan

( ) Treatment / Progress Notes

( ) X-Rays

( ) Other

I hereby authorize Turnagain Dental to release and/or request any and all information to/from:

Office: ____

Address: ____

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Telephone: ____

I understand that all information I hereby authorize to be obtained will be held strictly confidential and cannot be released without my written consent. I understand that this authorization will remain in effect until revoked by be in writing.

This release is in compliance with HIPAA regulations effective April 2013.

Signature: ____Date: _________________________