Northwestern Dental Center

AUTHORIZATION FOR RELEASE OF INFORMATION

RE: PATIENT'S NAME: ______________________________

DATE OF BIRTH: ____________ SOCIAL SECURITY#: ____________

CURRENT RESIDENTIAL ADDRESS: ______________________________

CITY: ____________ STATE: ________ ZIP CODE: ____________

TELEPHONE#: ( ) - ____________

I HEREBY AUTHORIZE NORTHWESTERN DENTAL CENTER AND ITS AGENTS TO RELEASE DENTAL RECORDS TO THE PERSONS AND/OR ORGANIZATIONS NAMED BELOW:

____
(NAME OF HEALTHCARE FACILITY, PHYSICIAN, AGENCY, ETC.)

____
(STREET ADDRESS)

____
(CITY) (STATE) (ZIPCODE)

IN ACCORDANCE WITH FEDERAL REGULATION, I HEREBY CONSENT TO THE RE-LEASE OF ALL RECORDS PERTAINING TO TREATMENT/DIAGNOSIS AND ALL OTHER CONDITIONS ON RECORD.

I UNDERSTAND THAT I HAVE THE RIGHT TO INSPECT AND COPY ANY WRITTEN IN-FORM\ATION TO BE DISCLOSED AND THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME BY GIVING WRITTEN NOTICE TO *NORTHWESTERN DENTAL CENTER*.

____
(PATIENT'S SIGNATURE) (DATE)

____
(WITNESS' SIGNATURE) (DATE)

____
(GUARDIAN IF PATIENT IS UNDER 18 YEARS OF AGE) (DATE)

PLEASE REMIT COMPLETED RELEASE TO:

NORTHWESTERN DENTAL CENTER
201 E. HURON ST.
GALTER PAVILION, STE: 2-246
CHICAGO, IL 60611