Authorization for Release of Dental/Health Care Information

1. I _______________________, hereby give my consent to Dr. ____________________
   to release to:

   Name: Kurt E. Schabes, DDS PLC Phone: 616-676-2223
   Address: 7210 Headley, P.O. Box 158, Ada, MI 49301-0158
   Email: contact@adafamilydentistry.com

2. Information from and copies of the dental/health care records of:
   Patient Name: ____
   Address: ____
   Birth Date and/or Social Security No.: ____
   Phone: ____
   Date(s) of Treatment: ____

3. Patient authorizes Dr. ____________________to release his/her entire dental/health care Records, including information related to HIV infection or AIDS, any communicable disease or infectious disease records and any other dental or health care records in any format.

4. Purpose of Release:

   __________Dental/Health Care __________Personal Information
   __________Insurance __________Other: _________________

5. This authorization shall be effective following the date of signature. However, I understand that this authorization may be revoked at any time by giving written notice to the above-named dentist. A photocopy of this authorization shall constitute a valid authorization.

6. If deemed necessary by Dr.____________________, I authorize this information to be sent via facsimile (fax) transmission.

7. The dentist and his/her employees are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

8. Patient or Representative: ____
   Date: ________________
   Relationship to Patient (if applicable):
   ____

   NOTICE TO RECIPIENT
   The recipient of the enclosed information is not authorized to use this patient's dental/health care records for any purpose other than for that stated above or to disclose any information from the record to any other person or facility without specific written authorization from the patient to do so.