RELEASE OF RECORDS

RECORDS TO BE RELEASED FROM: Dr. Robert M. Delaney, DDS
1121 South Higgins Avenue
Missoula, MT 59801
Fax 406-721-4893
Email rmdddsxray@dr-delaney.com

RECORDS TO BE RELEASED TO: ______________________________
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I, ____, herby authorize you to release my pictures, photographs, x-rays, films and other records in your possession. I UNDERSTAND THAT MY RECORDS MAY CONTAIN INFORMATION REGARDING THE DIAGNOSIS OR TREATMENT OF AIDS OR INFECTION WITH HIV, SUBSTANCE ABUSE, PSYCHIATRIC/PSYCHOLOGICAL OR MENTAL HEALTH CARE, OR SEXUALLY TRANSMITTED DISEASES. I GIVE MY SPECIFIC AUTHORIZATION FOR THESE RECORDS TO BE RELEASED. I UNDERSTAND THAT ONLY RECORDS GENERATED BY DR DELANEY WILL BE RELEASED.

I UNDERSTAND THAT THIS AUTHORIZATION MAY BE REVOKED BY ME AT ANY TIME, PROVIDED THAT I DO SO IN WRITING, UP TO THE EXTENT THAT THE DISCLOSURE HAD NOT ALREADY BEEN MADE. THE REVOCATION IS EFFECTIVE FROM THE TIME IT IS COMMUNICATED TO THE HEALTH CARE PROVIDER.

IT IS MY INTENT THAT INFORMATION FURNISHED IS PROHIBITED FOR ANY PURPOSE OTHER THAN THAT STATED ABOVE AND THAT THE RECIPIENT IS PROHIBITED FROM DISCLOSING THIS INFORMATION TO ANY OTHER PARTY TO WHOM DISCLOSURE IS NOT NECESSARY OR REQUIRED FOR THE PURPOSE STATED ABOVE.

Patient or guardian signature:____________________________________ Date_____________

Patient address: _____________________________________
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