Bay Hill Dental, Ltd.

DENTAL RECORDS/INFORMATION RELEASE FORM

OPTIONAL FORM THAT MAY BE COMPLETED BY THE PATIENT IF HE/SHE IS OVER 18 YEARS OLD

Please note, if this form is not completed, our office is prohibited from releasing any information regarding the patient (over 18 years old) to any individual, other than the patient.

I, _____________________________, give Bay Hill Dental, Ltd., permission to discuss and release any dental records and/or information regarding treatment, payment, and health operations to the following individuals:

____ (Name)	__________________________ (Relationship to patient)
____ (Name)	__________________________ (Relationship to patient)
____ (Name)	__________________________ (Relationship to patient)
____ (Name)	__________________________ (Relationship to patient)
____ (Name)	__________________________ (Relationship to patient)

____ Patient Signature

________________________ Date