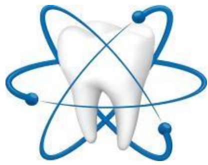

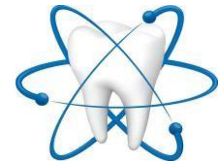

Eastern Dental Care PLLC
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•phone: 718-221-1300 •fax: 315-825-4788

AUTHORIZATION FORM FOR PATIENT RECORDS RELEASE (Please Print)

Patient name: ___________________________________ Date of Birth: ______________________
(Last, First, Middle)

Dr.Kailash Kaur/ Eastern Dental Care is authorized to release my information:
-dental records
-digital x-rays
-personal/organizations who may receive my information:

Specific description of the information to be used or disclosed (including dates) and place to release information (include address):
____
____
____

Describe each purpose of the use/disclose of my health information:
____
____
____

Section B: The patient or patient's representative must read and initial the following statements:
1. I understand that this authorization will expire on
(insert date or event) _____________________ Initials ___________
2. I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign. Initials ___________
3. I understand that I will get a copy of this form after I sign it. Initials ____________
4. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do, the revocation will not have any
effect on action already taken on this authorization. Initials __________

Signature of Patient/ Representative: _____________________________________ Date: _____________

If this authorization is signed by a patient's representative, please complete the following:
Printed name of patient's representative:
____
Relationship of representative to the patient:
____
Describe the representative's authority to act for this patient:
____
____
____