C. Steadman Willis, DMD

Authorization for release of information from our office:

Section A: I authorize the disclosure of my individually identifiable health information as described in Section B below. I understand this authorization is voluntary and made to confirm my directions. I hereby give my permission to Dr. Stead Willis to disclose my personal health information in the manner described herein.

Patient Name: _____

Address: _____

Phone number: _____

Section B: Name of specifically describe the persons and/or entities to whom you are authorizing Dr. Stead Willis to release your information to:

_____
_____
_____
_____
_____
_____

Personal Health Information to be disclosed: Copies of any x-rays and records of any exams, diagnoses, and treatment.

Purpose of Disclosure: I will be seen as a patient in an office other than Dr. Stead Willis' office.

Section C: Right to Revoke: I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it will not have any effect on the actions they took before they received the revocation.

Signature: I, _____, have had full opportunity to read and consider the contents of this authorization. I confirm the contents are consistent with my direction to the practice named above. I understand I have the right to inspect and/or copy the disclosed information described above. I also have the right to refuse to sign this authorization.

Signature: _____ Date: _____

Print Name: _____

Relationship to patient, if applicable: _____

THIS AUTHORIZATION EXPIRES AFTER ONE RELEASE