C. Steadman Willis, DMD

Authorization for release of your dental information to 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 _____ to disclose my personal health information in the manner described herein.

Patient Name: _____

Address: _____

Phone number: _____

Section B:

Name or specifically describe the persons and/or entities to which you are authorizing the practice named above to disclose your personal health information described below.

Release records to: **C. Steadman Willis, DMD** **Phone #: 919-286-2235**
1212 Broad St. **Fax #: 919-286-2237**
Durham, NC 27705

***Send images to:** info@steadwillisdmd.com **(In jpeg or dexis format)**

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 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: _____

If someone other than you, the patient, has signed this form on your behalf, please indicate the name of this person and their relationship to you.

Name: _____ **Relationship: _____**

THIS AUTHORIZATION EXPIRES AFTER ONE RELEASE