LAKE MANASSAS DENTAL CENTER, LLC

Authorization to Release PHI (Protected Health Information) Access, Inspect and/or Copy

Patient's Name: _____ Date of Birth: _____

SSN:

Doctor's Name: Long H. Nguyen

Practice Name: Lake Manassas Dental Center

I request and authorize the above listed doctor and practice to release healthcare information of the patient named above to:

Name: _____

Address: _____

City, State: _____ Zip Code: _____

This request and authorization applies to health care information relating to the following treatment, condition, or dates of treatment:

_____

_____

_____

Or _____ all heath care information
Or _____ Other:

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect that information.

_____ _____
Signature of patient or patient's authorized representative Date signed

_____
Relationship or status if signed by parent, legal guardian, personal representative, etc.

7915 Lake Manassas Dr.
Suite 115
Gainesville, VA 20155

PHONE (571) 261-9470
FAX (571) 261-9472
E-MAIL lakemanassasdental@comcast.net