Agatha M. Cayia, D.M.D.

Donna Medlin
Privacy Officer for Baylee Dental
352-307-3006

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize Baylee to **release** health information identifying me under the following terms and conditions:

At my request, I hereby authorize the use and disclosure of the patient information as described below **to another person listed below**: (please print)

1. Name: ____

Relationship: ___________________ **Phone** # if different than patient____________________

Address (if different than patient):

____

___________________________________ **Expiration date if needed:**_____

2. Name: ____

Relationship: ___________________ **Phone** # if different than patient____________________

Address (if different than patient):

____

___________________________________ **Expiration date if needed:**_____

The request and authorization applies to all healthcare information, financial and confirmations. Information limited relating to the following treatment conditions or dates:

____

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated _____________

Patient signature____

Print name: ____