



1650 Biglerville Road  
Gettysburg, PA 17325  
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### Permission to Release Diagnostic/Dental Information to Another Individual

Effective Date: \_\_\_\_\_

Patient's Full Name Printed: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

I give Samuels Dental Arts entitles permission to release diagnostic test results to, and discuss protected health information with the following person(s):

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

I give Samuels Dental Arts entities permission to leave any protected health information on an answering machine or voicemail.

Yes \_\_\_\_\_ No \_\_\_\_\_

Indicate your relationship to the patient: Patient \_\_\_\_\_ Patient Representative \_\_\_\_\_

Print Name (if other than patient) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**This authorization is valid until a new release form is completed.**