Robert T. Kroepel, Jr., D.M.D., P.C.
GENERAL DENTISTRY AND SLEEP CARE

243 Broad Street Milford, CT 06460 P (203) 877-1233 F 203-876-1166

Email: ContactUs@MilfordCTDental.com MilfordCTDental.com

AUTHORIZATION FOR USE OR DISCLOSURE OF PRIVATE HEALTH INFORMATION

Release for your dental or medical provider

To Whom It May Concern, please release my dental or medical records *(circle)* to / from Dr. Robert T. Kroepel, Jr.

And (*circle)* to/from (provider) _____.

Provider/Practice Address:

Phone/Fax/Email:

Patient Name:

Patient Date of Birth:

Telephone:

Parent or Guardian (if needed):

Provider/Practice Address:

Phone/Fax/Email:

Patient (or Guardian) Signature: _____Date:

Office Use:

Please send ___Recent dental images ___Previous sleep study ___Other

PERMISSION TO DISCLOSE OR DISCUSS MY TREATMENT AND RECORDS WITH DESIGNATED FAMILY OR CAREGIVERS

I, _____, direct Dr. Robert T. Kroepel Jr. and staff to disclose and release my protected health information All Information ___ Financial Only ____ Health Information Only to the following person:

Name:

Relationship:

Contact information:

This authorization will be effective:

__ Indefinitely OR __ until this date: _____, unless I revoke it.

Patient (or Guardian) Signature: _____ Date:

You may revoke this authorization at any time by notifying your health care providers in writing.

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