



NORTH ISLAND DENTAL ARTS
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AUTHORIZATION FORM FOR PATIENT RECORDS RELEASE (Please Print)

Patient name: _____ Date of Birth: _____
 (Last, First, Middle)

Dr.Kailash Kaur/ North Island Dental Arts is authorized to release my information:

- dental records
- digital x-rays
- personal/organizations who may receive my information:

Specific description of the information to be used or disclosed (including dates) and place to release information (include address):

Describe each purpose of the use/disclose of my health information:

Section B: The patient or patient’s representative must read and initial the following statements:

1. I understand that this authorization will expire on
 (insert date or event) _____ Initials _____
2. I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign. Initials _____
3. I understand that I will get a copy of this form after I sign it. Initials _____
4. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do, the revocation will not have any effect on action already taken on this authorization. Initials _____

Signature of Patient/ Representative: _____ Date: _____

If this authorization is signed by a patient’s representative, please complete the following:

Printed name of patient’s representative:

Relationship of representative to the patient:

Describe the representative’s authority to act for this patient:
