STACY J. MOON, D.D.S.
FAMILY & COSMETIC DENTISTRY

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____
Last Name First Middle

_____
Maiden Name Previously Married Name Date of Birth

I hereby request and authorize:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

To send a copy of the following reports from the patient's record:

X-ray Perio Charting Full Dental Records

To be released to:

Stacy J. Moon, DDS
6019 North Eagle Road
Boise, Idaho 83713

I acknowledge that data to be released MAY INCLUDE material that is protected by Federal Law that is applicable to ANY and ALL of the above.

My signature below authorize release of all such information.

_____
Signature of patient or responsible party Date

_____
Witness

I, the above signed, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent will expire upon completion of the transaction and no later than ninety (90) days from the date signed, unless otherwise stated herein.

To the party receiving this information: This information has been disclosed to you from the records, whose confidentiality is protected by Federal and/or State regulations prohibiting you make further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.