Gentle Excellence in Family and Cosmetic Dentistry

Family / Friends Records Release Form

I hereby authorize North Aurora Smiles to share/release any medical/dental information as requested to anyone I list below. The information that may be released would include but not limited to, medical/dental records, insurance information, appointment information, account information and treatment information. This information can be released by phone, in person, or via email. I am aware that North Aurora Smiles cannot control how the recipient uses or shares this information, and that laws protecting its confidentiality at North Aurora Smiles may or may not protect this information once it has been disclosed to the recipient. Information will not be released without a valid signature below. I also authorize North Aurora Smiles to release my medical/dental records via email. This authorization will take effect from the signature date and remain in place until I cancel this authorization in writing. I understand that North Aurora Smiles will continue to provide care, even if I do not authorize this release.

Patient Name: _____Date of Birth: _____

Release my protected health information to the following person upon request:

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Patient/Guardian Signature: _____

Date: _____