WAUSHARA DENTAL ASSOCIATES, S.C.

Authorization to release medical information to family member(s), guardian, and/or others.

Patient Name: _____

Patient Date of Birth: _____

I hereby authorize Waushara Dental Associates, S.C. to discuss and/or release my protected health information with the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that such revocation is not effective to the extent that the clinic has relied on the use or disclosure of the protected health information. I understand that information used or disclosed in accordance with this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Relationship to Patient