Millis Dental Care, PC
840 Main Street, Suite 112
Millis, MA 02054
T. 508.376.8996 • F. 508.376.8997

Authorization for Release of Protected Health Information

Please complete this form completely. You or your dependent's dental records cannot be released until this form is completed and signed by the patient (or if under 18, their parent or legal guardian)

Patient name: ______________________________

Parent/Legal Guardian name if under 18: ______________________________

Date of Birth: ______________________________

Address: ______________________________

I hereby authorize Millis Dental Care, PC to release the following health information:

X-rays dated from: ______________________________

Other: ______________________________

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reason for transfer: ______________________________

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This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date. Any additional authorization for disclosure beyond the above named request(s) is required.

Signature of
Patient/Guardian(if under 18): ______________________________

Date: ______________________________

Witness Signature: ______________________________

Date: ______________________________