Authorization to Release Records

I, (print patient or guardian name) _____,
hereby authorize the release of records or knowledge concerning my dental health to:

Zöe Dental

10 A Yorkshire Street, Suite 110

Asheville NC 28803

info@zoedental.com

Such records may include medical care and treatment, illness or injury, dental history, medical history, consultations, prescriptions, x-rays, and copies of all dental and medical records.

Patient Rights:

I have the right to revoke this authorization at any time by contacting our office ◆ I may inspect or copy the protected health information to be disclosed as described in this document ◆ Revocation is not effective in cases where the information has already been disclosed but will be effective going forward ◆ Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law ◆ I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing

Printed Name: _____ Date: _____

(patient or guardian)

Signed: _____ Date: _____

(patient or guardian)