# Release of Health Care Information

I,___________________________________, do hereby authorize High Tide Dental, PA to release my or my child(s) pertinent health information to the following people listed below for the purposes of coordination of my dental care. Dr. Homicz and his staff have explained to me the information that will be released.

I have received and read information on HIPPA, my rights and have had the opportunity to have all of my questions answered.

I do understand that I may revoke this authorization at any time with written notice to this office. I also understand that this authorization is effective for a period of one year and will again be reviewed.

Please release my/child(s) medical records to:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Patient's Name___________________________________________

Patient's Signature ___________________________________ Date_____________

Witness _____________________________________________

Parent / Responsible Party's Signature ________________________________