Lakefront Dental
111 North Wabash, Suite 1522
Chicago, IL 60602

Permission to Discuss Dental Records and Treatment with Third Party

I, _____, the undersigned, hereby authorize Lakefront Dental and its dentists, staff and designees to discuss and disclose my protected health care information listed below with:

Name: _____
Address: _____

I acknowledge that I understand the purpose of the request and that authorization is hereby granted voluntarily.

Patient Information -
Patient Name:
Address:
Phone:

Requested Information or Documents:
___ Dental Record
___ Radiographic Images (Xrays)
___ Photographs
___ Other (Specify):

I understand I may withdraw my authorization at any time by submitting a written request to Lakefront Dental at the address at the top of this form. I understand any revocation is not effective to the extent action has already been taken in reliance on this authorization. I understand information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by federal or state law. This authorization is not intended to affect a patient's ability to receive dental care. This authorization is limited to one year from the date of the signature. below

By my signature below, I consent and allow disclosure and discussion of the above listed information and/or documents.

Signature: _____ Date: _____