CRYSTAL LAKE SMILES
Dr. Parin Desai, DDS

185-2 Heritage Dr
Crystal Lake, IL 60014

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name _____

Patient Address _____

Patient Phone Number _____

I authorize the professional office of Dr. Parin K. Desai as named above, to release health information identifying me (including, if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released (name(s) or class(es) of recipients:

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state “at the request of the individual” as the purpose, if desired by the individual):

4. Expiration date relating to the release:

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated _____ Patient Signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to patient _____ Print Name_____

Signature of authorized signature _____