

# Scott Morris DDS & Associates, P.C.

66 Miller Drive, Suite 105  
North Aurora, IL 60542

## Medical/Dental Records Release Form

I hereby authorize Scott Morris DDS & Associates, P.C. to release any medical/dental information as requested from the individuals I list below. The information that may be released would include, but not limited to, medical/dental records, insurance information, appointment information, account information and treatment information. I am aware that Scott Morris DDS & Associates, P.C. cannot control how the recipient uses or shares this information, and that laws protecting its confidentiality at Scott Morris DDS & Associates, P.C. may or may not protect this information once it has been disclosed to the recipient. Information will not be released without a valid signature below. This authorization will take effect from the signature date and remain in place until I cancel this authorization in writing. I understand that Scott Morris DDS & Associates, P.C. will continue to provide care, even if I do not authorize this release.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Release my protected health information to the following physician/person/facility/entity:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_