AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO DESIGNATED PERSONS

Cameron R. Woodward DMD
560 Riverside Dr, Suite B-205, Salisbury, MD 21801 (410) 742-0166)

Patient Name: _____ Date of Birth: _____

I authorize the release of my health information to the following individuals:

1. Name: _____Relationship to Patient:_____
2. Name: _____Relationship to Patient:_____
3. Name: _____Relationship to Patient:_____

Information that may be shared (check all that apply):

- □ Appointment information
- □ Any of my medical/dental information
- □ Billing Information
- □ Test/lab Results
- □ All of the Above

I understand that I may cancel this consent at any time (by writing to the office of Cameron R. Woodward DMD), but that canceling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my dental provider or my dental clinic to share my information with someone.

This authorization expires when I cancel it in writing.

Signature of patient: _____ Date: _____