Roger M. Mueller, DMD
3716 Pontoon Rd.
Granite City, IL 62040
www.muellerfamilydentistry.com

Consent for Release of Information

This Authorization grants permission to my Spouse/Significant Other/Party Named Below to: make or confirm appointments; have access to radiology, laboratory, or test findings; have access to telephone communication and answering machine messages as well as other common means of communication; be made aware of my diagnosis, prognosis; and have access to my financial dental health information.

I hereby authorize Roger M. Muller, DMD to use and disclose my individually identifiable dental health information as described above. I understand that this authorization is voluntary. I understand that once this information is disclosed to my spouse / significant other, or the party named below, the released information may no longer be protected by federal privacy regulations.

PATIENT NAME: _____ **Date of Birth:** _____

Spouse / Significant Other/Other: _____

Relationship to Patient: _____

Address: _____

Phone: _____

If address or phone number is different from Patient's, please provide information:

_____

The patient must read the following statement:
1. I understand that this authorization will (Please check one)
_____*Expire 1 year from the date signed by the patient*
_____*Be effective for the lifetime of the patient unless revoked*

_____ _____
Patient/Responsible Party Signature Date