Ghina Morad, DMD
Beautiful Faces, Radiant Smiles

PATIENT CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize, Dr. Ghina Morad, to disclose my
(Name of Patient)

Treatment, Dental and Medical records to the following individuals:

1._____

2._____

(NAME OF PERSON (S) OR ORGANIZATION(S) TO WHICH DISCLOSURE IS TO BE MADE)

The following information:
I understand that my records are protected under the Federal regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____
(SPECIFICATION OF THE DATE, EVENT, OR CONDITION UPON WHICH THIS CONSENT EXPIRES)

_____ _____
(Signature of Participant) (Date)

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