PAUL A. KLOEK, DDS
W7154 Green Valley Road
Spooner, WI 54801
Phone 715-635-7888
www.greenvalleydentalcare.com

REQUEST TO RELEASE CONFIDENTIAL INFORMATION

I, _____ request and authorize _____

Patient Name | Name of Healthcare Provider

_____

Address of Healthcare Provider | Phone# of Healthcare Provider

to release/disclose ALL of my records, images, and information concerning my care to:

Green Valley Dental Care
Paul A. Kloek, DDS
W7154 Green Valley Rd, Spooner WI 54817
Ph: **(715)635-7888** Fax: **(715)635-6313**
Email: **info@greenvalleydentalcare.com**

If you DO **NOT** WANT specific information released/disclosed please indicate/list below:
□ Treatment Plan □ Medical History □ Exam Records □ Billing Records
□ Other: _____

Authorization & Signature:
This Authorization to Release Confidential Information is effective indefinitely unless revoked in writing by the patient or guardian.
Records may be released in digital, print, or verbal format unless stated otherwise.

_____

Comments

*I, the undersigned, authorize the release of my confidential information to **Green Valley Dental Care**, as described in the directions above. I understand this authorization is voluntary, that the information to be disclosed is protected by law, and that use/disclosure is to be made to conform to my directions.*

Patient/Guardian Signature: _____

Date: _____