



Dr. James P. Muir

## Authorization for Release of Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the information released may no longer be protected by federal privacy regulations.

I authorize James P. Muir D.D.S., P.L. d/b/a Citrus Park Dental to release any and all medical information necessary concerning my diagnosis, treatment, and medical condition requested by my health insurance company, Medicare, or any other third-party payers. I further authorize James P. Muir D.D.S., P.L. d/b/a Citrus Park Dental to contact my insurance company or health plan administrator and to obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to James P. Muir D.D.S., P.L. d/b/a Citrus Park Dental. I agree that these provisions will remain in effect until I provide written revocation to James P. Muir D.D.S., P.L. d/b/a Citrus Park Dental.

I authorize James P. Muir D.D.S., P.L. d/b/a Citrus Park Dental to release all medical information to my referring physician and to my primary care or family physician, and to other health care providers as necessary for my care.

In addition to my physician and insurance company, I authorize James P. Muir D.D.S., P.L. d/b/a Citrus Park Dental to release all medical information to the following people:

\_\_\_\_\_  
Name of person to whom we can release medical information and relationship to patient.

\_\_\_\_\_  
Name of person to whom we can release medical information and relationship to patient.

\_\_\_\_\_  
Name of person to whom we can release medical information and relationship to patient.

\_\_\_\_\_  
Name of person to whom we can release medical information and relationship to patient:

\_\_\_\_\_  
Name of person to whom we can release medical information and relationship to patient:

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form. I understand that I may see and copy the medical information being released as described above if I ask to do so, and that I will receive a copy of this form after I sign it.

\_\_\_\_\_  
**Patient's Signature**  
**(or parent or guardian's signature if patient is a minor)**

\_\_\_\_\_  
Date