Insight Dental Associates
Release of Information Form

Patient's Full Name	Patient's Social Security Number
Address	Patient's Date of Birth
City, State Zip Code	Patient's Telephone Number

I hereby authorize use or disclosure of protected financial, health and dental information about me as described below.

1. The following facility is authorized to use or disclose information about me:
   Insight Dental Associates
   1383 21st Ave N Suite B
   Fargo, ND 58102

2. The following person's (or class of persons) may receive disclosure of protected financial, health and dental information about me:

3. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
4. I may revoke this authorization by notifying Insight Dental Associates in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth or Social Security Number**
OR, if applicable –		
Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signator.

Official Use Only

Received	**Processed By**	**Uploaded**