104 W. 20th Street, Suite 3
Eudora, KS 66025-8112
Phone (785) 542-9105
Fax (866) 546-8283
eudoradentalcare@johnhhaydds.com
www.johnhhaydds.com

# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name, if applicable: _____

Other family members under the age of 18 for whom I am also signing:

_____

_____

I request and authorize (previous dental provider):

Provider Name: _____

Location and Contact Information, if it would be helpful to us _____

to release the healthcare information of the patient(s) named above to:

**John H. Hay, DDS, Inc.**
**104 W. 20th Street, Suite 3**
**Eudora, KS 66025-8112**

**(785) 542-9105**
**eudoradentalcare@johnhhaydds.com**

This request and authorization applies to:

☐ complete record history (digital, paper, models)

☐ limited recent electronic dental records:

_____

_____

_____

I also permit the above named provider to communicate with Dr. Hay or his representative regarding specific information in past records.

Signature _____ Date: _____