KALONS & GLIDEWELL, DDS, PA
AUTHORIZATION FOR RELEASE OF INFORMATION

SECTION A: I authorize the disclosure of my individually identifiable health information as described in Section B below. I understand this authorization is voluntary and made to confirm my directions. I herby give my permission to _____ to disclose my personal health information in the manner described herein.

Patient name: _____
Address: _____
Telephone number: _____

SECTION B: Persons/Entities Authorized to Receive and/or Use: Name or specifically describe the persons and/or entities to whom you are authorizing the practice named above to disclose or let use the personal health information described below:

Dr. Johanna Kalons and Dr. Kristina Glidewell
Charlotte Plaza Building
201 South College St., Suite 1465
Charlotte, NC 28244
Tel: (704) 378-6591 Fax: (704) 378-6594

Personal Health Information to Be Disclosed: Describe the personal health information you are authorizing to be used and/or disclosed:

Copies of any x-rays and records of any exams, diagnoses, and treatment.

Purpose of Disclosure: The disclosure is being made for the following reason: I will be seen as a patient in Drs. Kalons and Glidewell's office.

SECTION C: Right to Revoke: I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any affect on any actions they took before they received the revocation.

SIGNATURE: I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to the practice named above. I understand I have the right to inspect and/or copy the disclosed information described above, and have the right to refuse to sign this authorization.

Signature: _____ Date: _____
Print Name: _____
Relationship to Patient: _____