



**Karen J. Armstrong, D.M.D.**

**Bethany K. Tant, D.D.S.**

3160 Henderson Drive

Jacksonville, NC 28546

Phone: (910)346-5600

## Authorization to Release Healthcare Information

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_ Other Family Members: \_\_\_\_\_

I request and authorize:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

To release healthcare information of the patient named above to:

Name: Karen J. Armstrong, DMD & Bethany K. Tant, DDS General Dentistry

Address: 3160 Henderson Drive

City: Jacksonville

State: NC

Zip: 28546

Phone Number: (910) 346-5600

Fax Number: (910) 346-5396

This request and authorization applies to:

Healthcare information relating to the following treatment, condition and/or dates of treatment: \_\_\_\_\_

All Healthcare Information

Other: \_\_\_\_\_

► I understand that my express consent is required to release any healthcare information relating to testing, diagnosis and/or treatment.

Date: \_\_\_\_\_

Signature of patient or patient's authorized representative

Relationship or status if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)