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**AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION**

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Patient name \_\_\_\_\_

Patient number \_\_\_\_\_

Patient address \_\_\_\_\_

Patient phone number \_\_\_\_\_

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions: