

**AUTHORIZATION FOR USE & DISCLOSURE OF
HEALTH INFORMATION**

Wilkerson, Saunders & Anderson, DDS
831 Vermont St. · Lawrence, KS 66044
785-843-6060 · FAX: 785-843-4335 · wsadds@sunflower.com

Please release current dental records for the following patient(s) and send via mail or email (if digital) to the dental office above.

Patient Information:

Name _____

Address _____

City, State, Zip _____

Date of Birth _____

Dental Office Releasing Information:

Agency _____

Address _____

City, State, Zip _____

Information to be Released/Disclosed:

_____ X-rays* _____ Other (specify): _____

**Bitewings within the last 2 years; PAs within the year; Panoramic x-rays or FMS within 5 yrs.*

Right to revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this Authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific Authorization.

Exceptions to Right of Revocation: I understand that my written revocation will not affect the ability of the Agency to continue to use or disclose my health information to the extent that it has already acted in reliance on this Authorization. For example, the Agency cannot rescind disclosures it has already made, and may use my health information as necessary to bill and collect for services rendered.

Signature _____

Date _____

Printed Name _____