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**PEARL DENTAL LLC**

**1601 WALNUT STREET SUITE 1111**

**PHILADELPHIA, PA 19102**

**215-564-3830**

**PERSONAL REPRESENTATIVE AUTHORIZATION FOR MEDICAL RELEASE FORM**

I authorize this facility to speak to the following family members or my personal representative regarding:

□ All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis and records, nurse’s and doctor’s notes and any other non-medical information in my file.

□ Only the following types of information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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The above medical information shall only be released to the following persons:

Name of Personal Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_ Phone# \_\_\_\_\_\_\_\_\_\_

Name of Personal Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_ Phone# \_\_\_\_\_\_\_\_\_\_

Name of Personal Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_ Phone# \_\_\_\_\_\_\_\_\_\_

I understand that I may terminate this Medical Authorization form. I must notify this facility in writing regarding termination and effective date. This authorization shall remain valid (check one)

□ Until revoked in writing. □ Until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_

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

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

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_