Forrest R Jerkins, DDS PA

Consent for release of medical records and information

I,_____, (hereafter "Patient") hereby authorize Forrest R Jerkins DDS PA, (hereafter collectively referred to as "Practice") to use and disclose the entire medical record concerning Patient in accordance with the attached Notice of Privacy Practices (NOPP), I have received a copy of and reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release and hold Practice, its employees and agents harmless from any and all liability (including but not limited to negligence) arising out of or occurring under this consent.

_____

By Patient: Date:
(Please sign and date)

Or

_____

By Patient's Representative Date
(Print name, sign, and describe authority)

NOTE: Do not use this form for disclosure of HIV, Substance Abuse or Psychotherapy notes.

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