THOMAS VANBUSKIRK DDS
RECONSTRUCTIVE & COSMETIC
FAMILY DENTISTRY
6600 Cow Pen Road Suite #240
Miami Lakes, FL 33014
305-823-7521

CONSENT FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

I,_____, (hereafter "Patient") hereby authorize Thomas VanBuskirk DDS, (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:
(Print name and sign)

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.