MARKWAY & HAWORTH
GARDNER DENTISTS

Dr. Jason Haworth DDS
Dr. Greg Markway DDS

Phone: 913-856-7123
info@gardnerdentists.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name/Alias: _____ Social Security #: _____

I request and authorize GARDNER DENTISTS, LLC to release healthcare information of the patient named above to:

Person(s) Authorized:	Relationship to Patient:

☐ I hereby acknowledge that I have received a copy of Gardner Dentists, LLC's Notice of Privacy Practices. I understand that I have the right to refuse to sign the acknowledgement if I so choose.

☐ I authorize the release of the following specific information to the person(s) listed above:

☐ Yes ☐ No	I authorize the release of my healthcare records in their entirety to the person(s) listed above. This includes: Appointments, treatment, and health conditions
☐ Yes ☐ No	I authorize the release of any records regarding any financials including insurance and/or account billing to person(s) listed above.

Parent/Guardian Signature: _____ Date Signed: _____

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

☐ Patient/Representative refused to sign
☐ Emergency situation prevented us from obtaining acknowledgement at this time
☐Communication barriers prohibited obtaining acknowledgement (Explain)
☐Other (specify)

Employee Initials _____