JOHN L. HYATT, DDS, P.A.
Practice Limited to Periodontics
935 Fourth Street Drive, N.E.
Hickory, North Carolina 28601

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the office of John L. Hyatt, DDS, P.A. and it's duly authorized employees to (1) obtain, use, disclose and release protected health information about me to carry out treatment, payment and health operations pertaining to my dental treatment. This includes records to and from other dentist, physicians or other healthcare facilities (2) make calls to my home or other designated locations and leave messages on voice mail or in person with reference to appointment reminders, clinical care or any other items with regard to my dental care. (3) Also, to mail, e-mail or fax to my home or other designated locations items such as appointment reminders, patient statements, attending doctor's statements, billing statements or any other material that assist the practice with my dental care.

I also authorize the release of any information required in the processing of insurance claims.

I understand that I may, in writing, revoke this authorization at any time.

_____
Patient Name (Please Print)

_____
Patient Signature

_____
Authorized person to sign for patient (other than patient)

_____
Witness

_____
Date