Dr. Peter D. Balega, DDS, LLC
535 Newnan Street, Carrollton, GA 30177
Phone (770)834-6663 Fax: (770)835-5210

Authorization to Release Information

RE: _____ D.O.B: _____ SSN: _____

Address: _____

Print name of Parent/Guardian (if request is for a minor) _____

Information Requested/Released:
( ) Evaluation & Treatment Plan
( ) Treatment / Progress Notes
( ) X-Rays
( ) Other: _____

I hereby request and authorize **Dr. Peter D. Balega, DDS, LLC** to **release** any and all information indicated **to**:

Name: _____

Address: _____

_____

Telephone: _____ Fax: _____

I understand that all information I hereby authorize to be obtained will be held strictly confidential and cannot be released without my written consent. I understand that this authorization will remain in effect until revoked by me in writing.

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time by submitting my request in writing.

Date: _____ Signature of Client/Guardian: _____

Date: _____ Signature of Witness : _____

NON-COVERED SERVICES AGREEMENT

Fees for ancillary services such as copies of medical records, reports, third-party letters, medical leave forms, formulary questions and appeals, etc. are not covered by most insurance plans. Fees for these services are defined by Dr. Peter D. Balega, DDS, LLC and are based on copy costs and the amount of time required by clinical and administrative staff. The following rates will apply:

Photocopies: $.50 per page
Labor: $30.00 per hour

I understand that this is a non-covered service based upon my current insurance benefits and is to be paid at the time of service and is not reimbursable by my insurance plan.

Signature: _____ Date: _____