LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS
Elder Department
7500 Odawa Circle
Harbor Springs, MI 49740

RELEASE OF INFORMATION AGREEMENT

Name: _____ (Last) _____ (First) _____ (MI)

Maiden Name: _____ Alias: _____

Date of Birth: _____ / _____ / _____ Social Security Number: _____ / _____ / _____

Address: _____ (Street) _____ (P.O. Box) _____ (County)

_____ (City) _____ (State) _____ (Zip)

Home Phone Number: _____ / _____ / _____

Work Phone Number: _____ / _____ / _____

Drivers License Number: _____

I hereby authorize my confidential dental information to be released from the offices that hold information regarding any care and/or to release any confidential information between LTBB Elder department listed in this agreement:

Applicant / Client Signature: _____ _____ (Date)

Tribal I.D. number _____ _____

Agencies Releasing Information To Each Other

Little Traverse Bay Bands of Odawa Indians
Elder Department
7500 Odawa Circle
Harbor Springs, MI 49740
Phone No: (231) 242-1423
Fax No: (231) 242-1430

Dental provider:

_____

Blue Cross/Blue Shield or other insurance company:

_____