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HIPAA RELEASE FORM

Name:_____ Date Of Birth:____/____/____

We are unable to discuss your treatment with anyone unless you give us written permission.

{ } I authorize the release of information including the diagnosis, records, images, examination render and claims information. This information may be released to:

{ } My general and/or referring dentist and/or physician. Names and Phone numbers:

_____

{ } Spouse Name and number:_____

{ } Child(ren) Name(s) and phone number(s): _____

_____

{ } Parent(s) Name and number: _____

{ } Other Name and number:_____

{ } Information is not to be released to anyone

This release of information will remain in effect until terminated by me in writing.

Messages: Please call my { } Home { } Work { } Cell Number(s):_____

If unable to reach me: { } You may leave a detailed message

{ } Please leave a message asking me to return your call

{ } Other _____

I have received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practices legal duties with respect to my protected health information. I understand this practice reserves the right to change the terms of its Notice of Privacy, and to make changes regarding protected health information resident at, or controlled by, this practice. I understand I can obtain this practices' current Notice of Privacy Practices by request.

Patient/Guardian Signature:_____ Date:_____/_____/_____