Topsail Dental

HIPAA RELEASE OF DENTAL INFORMATION for a MINOR

Patient Name: _____ Date of Birth: ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination, pre-op and post op instructions rendered to my child(ren) and claims information. This information may be released to:

[ ] Spouse (Parent) _____

[ ] Other (Grandparent – other Guardian, etc.) _____

I do not authorize any release of information to the following people:

[ ] Spouse (Parent) _____

[ ] Other (Grandparent – other Guardian, etc. _____

This **Release of Information** will remain in effect until terminated by the guardian in writing.

Messages

Please call [ ] home phone [ ] my cell number

_____ _____

If unable to reach:

[ ] you may leave a detailed message [ ] please leave a message asking for a return call

The best time to call is (day) _____ between (time) _____

Guardian Signature: _____ Date: ____/____/_____

Witness: _____ Date: ____/____/_____