Medical Release Information

(HIPAA Release Form)

Name:_____ DOB:_____/_____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

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

How would you like us to communicate with you?

Please call: [ ] my Home [ ] my Work [ ] my Cell (_____)_____-_____

Email Address: _____@_____

[ ] **By checking this box, I consent to the following:** The dental practice or its service provider may contact me to provide healthcare information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing. The dental practice may:

[ ] Call Me
[ ] Text Me
[ ] Call and Text Me
[ ] Email Me

Signature:_____ Date:_____/_____/_____

Please call the office right away if you get a new telephone number!